

# Eradicating female genital cutting: Understanding reality conceptions

A study on perceptions of female genital cutting in Hargeisa, Somaliland (Somalia)



By Ingvild Bergom Lunde

Supervisor: Mette Sagbakken

Co-supervisor: Ingvil Krarup Sørbye



Department of Community Health

Institute of Health and Society

The Faculty of Medicine

University of Oslo

May 2012

Thesis submitted as a part of the Master of Philosophy Degree in International Community  
Health



## **Abstract**

According to some sources little progress is being made in eradicating the cutting of female genitalia. This study therefore explores perceptions of female genital cutting (FGC) and of abandonment of the phenomenon. The data were collected over a period of three months in Hargeisa, the capital city of the self-declared Republic of Somaliland, within the internationally-recognised borders of Somalia. This study takes as its starting point the assumption that meanings are to some extent socially and culturally constructed. Therefore a qualitative methodology using in-depth interviews and observation has been employed. Two main groups of research participant were interviewed: (1) Representatives of organisations working directly to eradicate FGC; and (2) individuals not working directly to eradicate FGC. It was found that there is an increasing use of medical staff and equipment when a girl undergoes the procedure of FGC; religion is both an important barrier and facilitator of eradication; the use of terminology is crucial in understanding current perceptions of FGC and of eradication of FGC; traditional gender structures are currently being challenged in Hargeisa; it is important to understand how knowledge on FGC is constructed; and finally that FGC eradication is influenced by complex issues related to the 'development' of Somaliland. The findings of this study suggest that it is important to consider current perceptions on practices of FGC in order to gain useful knowledge on the issue of eradication. The study concludes that eradication of FGC is not a straight-forward path - it is rather a multifaceted process which is constantly negotiated in a diversity of social settings.



## Acknowledgements

A couple of months ago I did not know that I, as many other students who has gone before me, could claim that the master thesis is done. At the very end of more than a year of a rollercoaster filled with happiness and frustration I too see that this achievement is not mine alone. I am indebted to several people for inspiring me to write this thesis in one way or another:

- Firstly, I want to thank all the research participants who openly shared their knowledge and taught me, perhaps more than I realise, about research and Somaliland. This research project would simply not exist without anyone of you.
- My supervisor Mette Sagbakken has challenged and supported me long before I knew what would come out of this research project. Thank you for constructively criticising so much of what I have done and written – and for encouraging phone calls all the way to Somaliland.
- My co-supervisor Ingvil Krarup Sørbye has provided me with good knowledge on Somaliland and medical aspects of reproductive health – thank you for informative lunches in Oslo, and proactive contributions throughout the fieldwork.
- The research project “LEVE-livelihoods in developing countries” at the Centre for Development and the Environment (SUM) has provided me with a nice office space, a generous scholarship and much needed coffee.
- Thank you also to Ivar Helles Legat for financial support for my fieldwork.
- Without the daily visits from Arab Hersi and his family I do not know what life in Hargeisa would have been – thank you for unconditionally treating me and Andrew as your family.
- Thank you to Espen and Ingjerd Heen for having the courage to stay in Somaliland and for unreservedly opening your doors before I even arrived in Hargeisa.
- A big thanks to colleagues at the Department of Student and Academic Affairs who have made the work/study combination smooth, and brought me back to reality once a week.
- A big hug to my family who is always curious of my whereabouts and are bothered to listen to what I learn (every single day if needed!).
- Last, but not least, my dearest Andrew David Wilson: Your belief in me and encouragement to follow my desires, make my dreams come true. A simple ‘thank you’ is not enough to cover all the hours you have spent listening to me and giving feedback on this thesis. How about a juice-maker?

Please note that, unless otherwise stated, all photos used in this study are taken by me.



## **Abbreviations**

FGC	–	Female Genital Cutting
FGM	–	Female Genital Mutilation
FGM/C	–	Female Genital Mutilation/Cutting
WHO	–	World Health Organisation
UNICEF	–	The United Nations Children’s Fund
TBA	–	Traditional Birth Attendant
MCH	–	Maternal Child Health (clinic)
NGO	–	Non-Governmental Organisation
INGO	–	International Non-Governmental Organisation
IDP	–	Internally Displaced Person





## Contents

<b>Abstract .....</b>	<b>ii</b>
<b>Acknowledgements .....</b>	<b>iv</b>
<b>Abbreviations .....</b>	<b>vi</b>
<b>Contents .....</b>	<b>viii</b>
<b>Chapter 1: Introduction .....</b>	<b>1</b>
Research problem statement .....	1
Structure of the thesis .....	2
<b>Chapter 2: Background information .....</b>	<b>3</b>
Somalia .....	3
Somaliland .....	4
Female genital cutting .....	5
<b>Chapter 3: Female Genital Cutting, eradication and Somaliland: A literature review .....</b>	<b>9</b>
The construction of circumcision through terminology .....	9
History of eradicating FGC at a global scale .....	10
The Western Discourse on FGC and the African focus .....	13
Changes in practices of FGC at a global scale .....	15
Male circumcision .....	17
Reviewing literature on FGC, eradication and Somaliland .....	17
History of eradicating FGC in Somalia and Somaliland .....	18
FGC practices in Somaliland .....	19
Current initiatives designed to eradicate FGC in Somaliland .....	20
Changes in practices of FGC in Somaliland .....	21
FGC in the Somali exile .....	22
Justification of research enquiry .....	22
<b>Chapter 4: Research Design .....</b>	<b>25</b>
Research Design .....	25
Epistemology .....	26
Theoretical perspective .....	27
Methodology .....	28
Arriving at the research question .....	28
Research objective .....	29
Methods .....	30
Data analysis and writing up of the final report .....	38
Ethical considerations .....	39

Positionality and pre-understandings .....	42
Limitations of the research design.....	45
Strengths of the research design.....	45
<b>Chapter 5: Perceptions of female genital cutting and of abandonment in Hargeisa: A presentation of the findings .....</b>	<b>47</b>
Descriptions and explanations of FGC .....	47
FGC initiatives and activities .....	60
Ideas, opinions and understandings about eradication and abandonment of FGC.....	67
<b>Chapter 6: Understanding reality conceptions: A discussion of the findings.....</b>	<b>77</b>
The biomedical discourse of FGC .....	77
Religion: A crucial part of a collective consciousness .....	80
Abuse and use of terminology .....	84
Gender roles in the sunna generation.....	86
FGC and the construction of knowledge .....	87
Eradication of FGC is not just a story of vaginas.....	90
<b>Chapter 7: FGC and eradication: Reality conceptions matter - Conclusion.....</b>	<b>93</b>
<b>Reference list.....</b>	<b>97</b>
<b>Appendix 1: Interview guide for initial interviews .....</b>	<b>101</b>
<b>Appendix 2: Interview guide for organisations working on FGM/C .....</b>	<b>102</b>
<b>Appendix 3: Interview guide for interviews with ‘lay’ people .....</b>	<b>103</b>
<b>Appendix 4: Ethical approvals and statement of confidentiality made by research assistant .....</b>	<b>105</b>
<b>Appendix 5: Information sheet for research participants.....</b>	<b>110</b>

## **Chapter 1: Introduction**

Despite the global campaign to eradicate genital cutting of women, female genital cutting (from now referred to as FGC) still seems to be strongly embedded in Somali culture, with several sources claiming a prevalence rate of about 95 per cent (Black, 2010; Ismail, 2009; Sorbye & Leigh, 2009). FGC is claimed to have severe medical implications and no health benefits (WHO, 2000). It is assumed that FGC plays a major role in Somali culture at the same time as it is implicated in major problems related to women's reproductive health (Black, 2010; WHO, 2000). FGC is thus an issue well worth exploring. In exploring FGC there seems to be no consensus over what FGC, and eradication of the phenomenon constitutes, and there are many uncertainties about FGC in Hargeisa. The term eradication implies that there is an intentional driving force determined to destroy or remove FGC completely. Abandonment implies that people practicing FGC have capacity to stop FGC based on their own will. Abandonment and eradication, nonetheless, interlink in a dialectical relationship. Initiatives designed to eradicate FGC can result in abandonment, at the same time as abandonment can potentially lead to eradication. Eradication of FGC practices thus play out in a culturally and socially constructed world which is constantly being negotiated. It is therefore important to explore perceptions of the phenomenon.

### **Research problem statement**

This study does not aim to provide a solution to issues of FGC. Nor does it argue for or against eradication approaches. Rather, it insists that one of the major challenges of eradication concerns a complex question of reality conceptions about what FGC constitutes. It is these reality conceptions that will be described and analysed in this study. This is achieved by letting a range of people express their thoughts and opinions on practices of FGC and on campaigns to eradicate FGC in Hargeisa, Somaliland. The argument of this study is that it is perceptions of reality that bring FGC into being and it is therefore perceptions of reality that need to be considered if one is to understand the practice. These perceptions are negotiated at different times and in different places by a diversity of social actors. The phenomenon may, or may not, be eradicated in the process of negotiating what 'reality' is or should be.

The overall objective of this study is to:

- Explore how FGC, and initiatives designed to eradicate FGC, are perceived in Hargeisa

To achieve this, the study has the following aims:

- To explore and map current initiatives designed to stop FGC in Hargeisa

- To explore how practices of FGC are perceived in Hargeisa
- To explore how initiatives designed to stop FGC are perceived in Hargeisa

## **Structure of the thesis**

The overall structure of the thesis takes the form of seven chapters, including this introductory chapter. The following is a layout of the following six chapters:

*Chapter two* begins by presenting essential background information on the research setting which is Hargeisa, Somaliland. This is followed by essential background information and definitions of the research topic, FGC, which is lastly presented.

*Chapter three* consists of an in-depth review of the literature on FGC, eradication and Somaliland. It begins with a short discussion of FGC terminology before focusing on the history of initiatives designed to eradicate FGC both globally and in Somalia/Somaliland. Emphasis is put on how FGC and eradication of the practice have been conceptualised over time. Changes in practices of FGC, both globally and in Somaliland and Somalia, are also discussed. Male circumcision and FGC in the Somali communities living abroad are also shortly described.

*Chapter four* presents the research design. It presents the epistemology and theoretical foundations of the project, locating the study within social constructionism and discourses of power. The aims, research objectives and data collections methods are then identified. Here it is detailed how the data were collected using a qualitative methodology. In addition, it discusses the strengths and limitations of the research design and reflects on the positionality and pre-understandings of both the researcher and the research assistant.

*Chapter five* is a presentation of the findings of the study. It is divided into three main categories: (1) Descriptions and explanations of FGC; (2) FGC initiatives and activities; and (3) ideas, opinions and understandings about eradication and abandonment of FGC. Together these categories encapsulate how FGC, and abandonment of FGC, is perceived in Hargeisa.

*Chapter six* provides an in-depth discussion of the findings presented in chapter 5. It argues that reality conceptions are important in order to understand how practices of FGC change, and thus how eradication of FGC may be facilitated.

*Chapter seven* offers concluding remarks to summarise the research project.

## Chapter 2: Background information

### Somalia

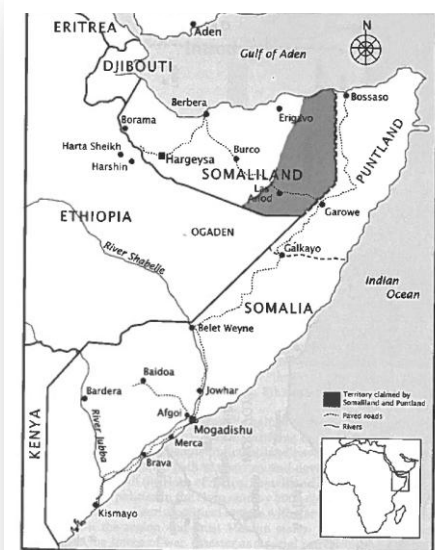
Figure 1: The Somali Republic flag



For the last 20 years Somalia, located on the Horn of Africa, has been in a state of chronic conflict and instability (Abby & Mahamoud, 2005). Furthermore, Somalia has some of the worst indicators of human development in the world (MICS, 2006). In 2006, for instance, the maternal mortality ratio (MMR) in Somalia was measured to be 1044 per 100 000 live births (MICS, 2006). In comparison Norway had just 7 deaths per 100 000 live births (WHO, 2011a). Although MMR can be hard to measure and population data on Somalia is often lacking, it is nevertheless an indication of the status quo and illustrates the extent of global inequality (Linard, Alegana, Abdisalan, Snow, & Tatem, 2010; WHO, 2012).

Since the late 1880s today's Somalia has been occupied by both British and Italian powers. At this time there was already a distinction between Somalia and Somaliland (Bisset, Galloway, Parker, & Vogel, 2010). Somalia was firstly occupied by Italian and later British powers. Conversely, Somaliland was firstly colonised by British and later Italian powers. In 1960 Britain and Italy combined their protectorates in the form of the independent United Republic of Somalia (Bisset et al., 2010).

Figure 2: Map of Somalia and Somaliland (Bradbury, 2008)



In 1969 Siad Barre led a military coup which resulted in him becoming the third President of Somalia. Supported by the Soviet Union, Somalia experienced economic growth, the introduction of gender policies and certain degree of social stability throughout Barre's dictatorship. Barre envisioned a greater Somalia including all Somali speaking areas of neighbouring countries (Djibouti, Kenya and Ethiopia) (Lewis, 2002). In 1991, however, Barre was overthrown by a rival tribe. Somaliland in the North-West of the country declared its independence in May 1991, and Puntland in the North-East declared

its autonomy in 1998 (Bisset et al., 2010). Since 1991, southern Somalia has experienced frequent armed conflicts and there has been no functioning government (Abby & Mahamoud, 2005).

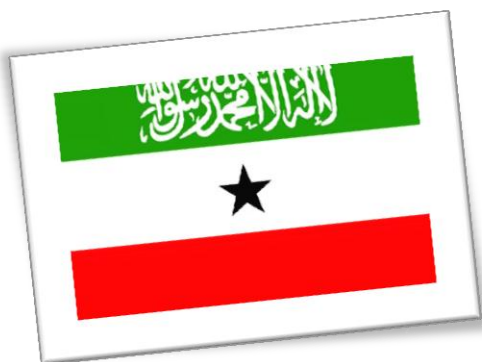
The Somali people belong to one of the following six tribes: Dir, Isaaq, Darod, Hawiye, Digil and Rahanwein. Each of these tribes have several, complex sub-units. Simply put, all the Somali leaders, warlords and militia groups are from the major tribes in the country, and are often in conflict with one another. The other clans are considered minorities, and are often oppressed.

It is evident that a large number of individuals from Somalia have been displaced for several years, or even a life-time (IDMC, 2010; Petchesky, 2008). Somalia is recently reported to have at least 1.5 million internally displaced persons (from now referred to as IDPs), making it one of the five countries in the world with the most IDPs (IDMC, 2010). Many Somalis have also crossed the internationally recognised borders of Somalia and now live in exile. Today Somalis are found in many countries in Europe, North America and Australasia. Somali identity is therefore global and very diverse. This study does not go in-depth into Somalis in exile as the data collection was conducted in Somaliland. However, the diversity of Somali culture and the influence of the Somali diaspora should not be dismissed.

Unless otherwise specified, Somalia from now refers to the southern parts (i.e. not Somaliland and not Puntland) of the internationally recognised borders of Somalia.

## Somaliland

Figure 3: Republic of Somaliland flag



Hargeisa is the capital city of the Republic of Somaliland, located in the North-West zone within the internationally recognised borders of Somalia. Islam is the predominant religion in Somaliland. Although Somaliland declared its independence on 18<sup>th</sup> May 1991, it is not internationally recognised as an independent country. The main political group in the independence struggle was the Somali National Movement which was in war with the Barre regime until it collapsed. The

Somali National Movement mainly consists of the Isaaq-clan family which is now the major tribe in Somaliland.

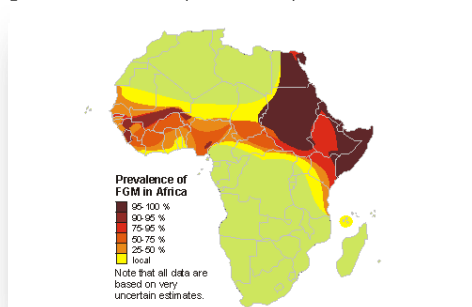
Between 1994 and 1997 there was an internal war in Somaliland between different stakeholders struggling for power. Somaliland did not, however, reclaim its union with Somalia after this war, rather it became an even stronger independent political entity (Bradbury, 2008).

Although unrecognised, since declaring its independence Somaliland has conducted democratic elections and is commonly referred to as a relatively stable country undergoing recovery and reconstruction (Bisset et al., 2010). However, Somaliland still faces severe challenges; challenges which are often exacerbated by the fact that it remains an unrecognised state. Furthermore, as can be seen in figure 2 there are on-going border disputes between Somaliland and Puntland. In addition, occasional news reports suggest that terrorist groups are growing in both Somalia and Somaliland. The future of Somaliland is therefore highly uncertain (Bradbury, 2008).

The data collection for this thesis was conducted in Hargeisa over a period of just over 3 months. Due to security restrictions the researcher did not collect data outside of Hargeisa. In this thesis Somaliland is understood to be an independent country as that is how it has been referred to by the research participants. Observations made by the researcher and most literature supports this view (Bradbury, 2008). However, as will be discussed, it is not always clear what geographic parts the literature refers to when ‘Somalia’ is scrutinised.

## Female genital cutting

**Figure 4: Map of Africa showing FGC prevalence rates (Afrol, 2011)**




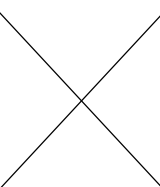


FGC is a widespread and worldwide phenomenon that is predominately practiced in Africa and Asia. Practices of FGC exist across all religions, and the origins of the practice are to a large extent unknown (Talle, 2010). In recent years, however, the practice has spread and it now exists in many refugee populations in Europe, North America and Australasia. As can be seen in figure 4, Somalia may have one of the highest prevalence rates of FGC in the world. Sources claim a

prevalence rate of between 95 and 98 per cent (Black, 2010; Ismail, 2009; Sorbye & Leigh, 2009). It is further claimed that of the Somali girls that are circumcised 98 per cent have undergone pharaonic type which is considered the most severe type of the practice (Ismail, 2009).

The World Health Organisation (from now referred to as WHO) defines female genital mutilation (from now referred to as FGM) as “the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons”. Table 1 illustrates how the WHO defines and classifies four types of FGM. As will be argued, the term ‘FGM’ does not correspond directly with the local definitions of the phenomenon in Somaliland.

**Table 1: Classifications of female genital mutilation (Ismail, 2009; WHO, 2003, 2011b)**

	<b>Type I:</b> Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
	<b>Type II:</b> Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
	<b>Type III:</b> Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
	<b>Type IV:</b> All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

In Somaliland it seems that two main types of FGC exist: ‘Pharaonic’ and ‘sunna’<sup>1</sup> (Talle, 2010). The term ‘pharaonic’ circumcision is usually used to describe type 3 as defined by the WHO. This type is said to involve cutting the labia minor and majora, excision of the clitoris and fusing the vaginal walls (Talle, 2010). ‘Sunna’ is a term that is said to correspond to the WHO type 1 definition, meaning that the clitoris is partly or totally removed. As will be seen, however, ‘sunna’ carries a diversity of meanings and definitions beyond the WHO classification of FGM type 1. The term female genital cutting (FGC) is used in this study when referring to all types of cutting of female genitalia for non-medical reasons. ‘Sunna’ and ‘pharaonic’ circumcision are also often used as these two terms carry different meanings in Somaliland society

The health complications reported on FGC are diverse and are often presented in a lifeline such as that illustrated in the following posters which were displayed at an out-patient ward in a hospital in Hargeisa. It should be noted that these posters only refer to the health complications of the pharaonic circumcision, not the sunna type (also adapted from Ismail, 2009, pp. 16-19):

<sup>1</sup> ‘Sunna’ circumcision is commonly spelled in two ways: ‘Sunna’ and ‘sunnah’. This study uses ‘sunna’ consistently, except in the cases where in-text quotations are used and the cited author uses the spelling ‘sunnah’.





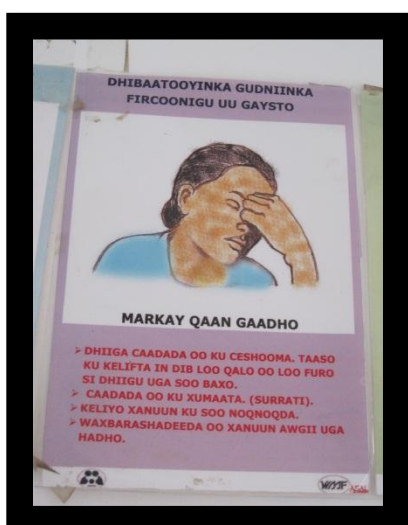
### Consequences of pharaonic circumcision at the time of circumcision:

- Shock, pain, fear
- Haemorrhaging
- Intended and unintended lacerations and cuts
- Potential spread of HIV and other infections due to unsterile equipment being used



### Consequences of pharaonic circumcision within the 10 first days of circumcision:

- Infection
- Retention of urine
- Potentially a need to re-suture if the vaginal walls fail to fuse
- The girl is unmoveable and isolated as her legs are tied together



### Consequences of pharaonic circumcision at the onset of menstruation:

- Stagnation of menstrual blood and other vaginal secretions may cause dysmenorrhoea and severe abdominal cramps
- Kidney pain and diseases
- Recurrent urinary tract infection
- May need to create a bigger opening, but girl will then lose her proof of virginity for the time of marriage



### Consequences of pharaonic circumcision at the time of marriage:

- De-infibulation: Needs to be recut or forced open by husband as the opening can be too small for sexual intercourse
- Pain during sexual intercourse due to FGC-scar
- Risk of infertility and not being able to deliver
- Cysts, tumours and risk of ovarian cancer



### Consequences of pharaonic circumcision during delivery:

- Prolonged delivery
- May need to cut the opening even more
- A potential need for caesarean section
- Prevention of the normal and gradual dilation of vagina
- Fistula
- Uterine rupture
- Maternal death
- Maternal distress
- Foetal complications include: Large caput formation, moulding of head, intracranial haemorrhage, foetal distress, intrauterine death



### Post-natal complications of pharaonic circumcision:

- Infection of the lacerations
- Delayed healing of wounds
- Anaemia
- Prolapse of bladder or rectum to bulge into vagina due to severe stretching of the vaginal wall muscles

### **Chapter 3: Female Genital Cutting, eradication and Somaliland: A literature review**

In June 2007 the Norwegian Broadcasting Cooperation (NRK) showed a report on national television which claimed that a significant number of Somali-Norwegian girls had been circumcised in Somaliland (Hellevik, 2007). A few months later anthropologist Aud Talle (2010) published a report claiming that circumcision of Somali-Norwegian girls in Somaliland was a phenomenon that barely existed and argued that NRK's data collection methods were faulty. NRK insisted that their research was sound, claiming that discrepancies in the data were the result of local authorities in Somaliland threatening circumcisers to silence on the topic of circumcising Somali girls in exile (Hellevik, 2007). This infamous controversy illustrates the challenges of reliable knowledge on the topic FGC. Arguably the only way one can really 'the truth' of the phenomenon is by checking every single girl through a physical examination. This is one reason why there is very little literature on FGC in Somalia and Somaliland and the literature that is found is often contradictory and/or outdated (Mazzilli & Davis, 2009).

This chapter reviews the literature of relevance to this research. It begins with a short discussion of the terminology of FGC before looking at what research has already been done on the topic of eradicating FGC. Thirdly, it looks at the literature on FGC practices in Somalia and Somaliland in particular. Male circumcision and FGC in the Somali exile are shortly discussed as it is seen as relevant to (but not the focus of) the research project. Finally, a justification for the research enquiry will be presented.

#### **The construction of circumcision through terminology**

Phenomena of cutting female genitalia are referred to in several ways, such as female circumcision, female genital mutilation, female genital surgery and female genital cutting (Johnsdotter, 2012; Obermeyer, 1999; Nahid Toubia, 1994; WHO, 1997). These phenomena involves "the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons"(WHO, 2011b, p. 1).

Although it has been criticised for being a culturally imperialist term that "implies a deliberate attempt [...] to hurt or disfigure members of their own families", female genital mutilation is by now a widely accepted and used term (Lewis, 1995, p.7; Tiilikainen Johansson, 2008). The WHO and United Nations institutions have adopted this term, but often use it in combination with female genital cutting (i.e. FGM/C), offering a more 'neutral' term so as to respect the local communities in which it is practiced (Kunnskapssenteret, 2009). By using the acronym FGM instead of female genital mutilation one "telescopes the words, inevitably losing some of their

meaning” (Obermeyer, 1999, p. 84). However, it still categorises the phenomenon as a rare disorder (Obermeyer, 1999). Female genital cutting can be viewed as a more culturally sensitive term than FGM, but has been criticised for not acknowledging the practice as harmful (Talle, 2010).

Obermeyer (1999) points to the difficulties of meaningfully translating the phenomenon into English. The term female genital surgery or female genital operation is sometimes used to describe the practice in a neutral way. However, it has been criticised for implying that it is a safe medical procedure where anaesthesia and clean equipment should be, and always are, used (Lewis, 1995). According to Lewis (1995) the anthropologist and African politician Jomo Kenyatta introduced the term ‘irua’ to Western readers. The term ‘irua’ is used for both girls’ and boys’ initiation into adulthood, and includes both cutting of genitalia and associated social and religious rites. Lewis (1995) explains that using the term ‘irua’ locates the phenomenon within its distinctive cultural context. Female circumcision is, however, often claimed to be a “medically incorrect term” (Morris, 1996, p. 44). Obermeyer (1999) explains that if one translates the cutting of female genitalia into female circumcision it symbolises that it is the equivalent procedure to that of male circumcision where the prepuce of the penis is removed.

No term seems to be value-neutral or suitable in all contexts when referring to the cutting of female genitalia. It is thus a complex phenomenon that cannot easily be simplified into one term (Lewis, 1995). As already stated in the background chapter, Talle (2010) identifies two words that can be used for FGC: ‘Pharaonic’ and ‘sunna’. Pharaonic, she argues, refers to the severe form of the practice where most external genitals are cut and the girl is infibulated (i.e. the vaginal walls are fused by sowing or stitching). Sunna generally refers to a prick in the clitoris which makes it bleed (Talle, 2010). This study refers to the phenomenon as FGC as it is viewed as a term that best captures the variety of perceptions of FGC practices within Somaliland. This study thus uses FGC to refer to all types of cutting female genitalia. ‘Uncircumcised’ is understood to mean no type of FGC being practiced. As will be seen, however, this understanding of ‘uncircumcised’ does not always correspond to commonly held views in Somaliland.

### **History of eradicating FGC at a global scale**

There is a diversity of initiatives that aim to eradicate or reduce FGC at political, legal, international, regional and national levels. The actors involved are plentiful and include governments, local non-governmental organisations (from now referred to as NGOs), international non-governmental organisations (from now referred to as INGOs), multilateral/bilateral organisations and civil society (Toubia & Sharief, 2003). The following is a

historical description of approaches to stopping FGC. What is noticeable is that the literature on eradicating FGC (even long before the 1970s) is mainly produced by Westerners.

There is not much literature found on initiatives designed to stop FGC before the 1960s. Boddy (2008), however, analyses how British powers attempted to stop FGC in North Sudan in the early 1900s. Boddy (2008) explains that there were three phases to this attempt: (1) Midwifery reform engaged in local practice; (2) Western-style education programmes that attempted to reshape gender roles; and (3) legal measures to reduce the severity of the practice. According to Boddy (2008), one of the main justifications for these interventions was to increase birth-rates in order to make Sudan independent from Egypt. At the time Sudan had a limited workforce and could not manage self-sufficiently. The British powers believed that the reason for a low population growth was due to the widespread practice of pharaonic circumcision, or infibulation, in Sudan. It was believed that FGC was a maternal and neonatal problem inhibiting population growth, and therefore there was a need to boost reproduction through eliminating pharaonic circumcision. Boddy (2008) argues that the methods employed to stop the practice resulted in contradictory outcomes with a lack of compatibility between “British and Sudanese concepts of self” and with little impact on the reduction of the practice (Boddy, 2008, p. 4).

Johnsdotter (2012) is another academic who offers a comprehensive account of the history of FGC in Africa before the 1970s. Although the account does not look at eradication initiatives *per se*, it is a useful historical account of the existence of FGC from early references of the phenomenon by “the father of history” Herodotus in about 480-420 BCE up until recent years (Johnsdotter, 2012, p. 93). However, Johnsdotter (2012) too found that there is little historical literature on FGC and in her review she found only short annotations on the phenomenon before the 1970s.

Johansen, Bathija, and Khanna (2008) claim that the international discussion on eradicating FGC started in the 1960s. They argue that in the 1960s and 70s FGC was seen by the international community as a culturally sensitive topic “that was best dealt with directly by the affected countries themselves” (Johansen et al., 2008, p. 83). Nonetheless, Johansen et al. (2008) explain that it was not until the countries themselves questioned the practice and requested assistance from abroad that the international community responded. They insist that because of knowledge of the health risks of FGC grew in the affected populations, the WHO increasingly responded.

In 1976 the American writer and activist Fran Hosken published an influential report on the practice of cutting female genitalia, and based on the now infamous ‘Hosken-report’ the term

‘female genital mutilation’ was coined (Hosken, 1976; Johnsdotter, 2012; Wade, 2011). Following up the Hosken-report, the first international conference on FGC was held by the WHO in Khartoum, Sudan in 1979. The conclusion of this conference was that a total eradication of the phenomenon was needed. Thus the idea of a step-by-step approach aiming for milder forms of FGC, and reducing physical complications by use of medical facilities, was at this point considered unacceptable (Toubia & Sharief, 2003). Toubia and Sharief (2003) argue that this conference initiated the involvement of several actors from the international health and development community to stop the practice. Over the next twenty years the philosophy of total and rapid eradication of FGC dominated FGC activities and the medical aspects, i.e. the negative health consequences, of the practice were emphasised (Toubia & Sharief, 2003). Toubia and Sharief (2003) explain that it was believed that FGC-initiatives would be more acceptable to the communities practicing FGC if approached by the international community through a biomedical focus.

In the 1980s the ‘United Nations Decade for Women’ focused on gender inequality and women’s health. Johansen et al. (2008) explain that FGC was not a central focus and merely recognised at this point as a priority area. However, the WHO regional committee for Africa passed a resolution in 1989 encouraging Member States to deal with the practice (Johansen et al., 2008).

At the World Conference on Human Rights in Vienna in 1993 it was concluded that gender-based violence was a breach of human-rights (Toubia & Sharief, 2003). Although FGC was not directly addressed in the beginning of the 1990s, increasingly international agencies dedicated attention towards the issue through reports and conferences (Toubia & Sharief, 2003). In 1997 an internationally accepted document issued by the WHO, United Nations Populations Fund, and United Nations Children’s Fund (from now referred to as UNICEF) set the standards for future FGC initiatives. Work on FGC was then understood as gender-based violence and placed within a human rights framework. It was in this document that the four categories of cutting female genitals were classified (Johansen et al., 2008; WHO, 1997). Increasingly the focus was on how to stop the practice, “rather than whether it is appropriate to intervene” (Toubia, 1994, p. 716).

In the 2000s it was questioned whether any progress had been made in the field of eradicating FGC over the past 30 years and if a decrease in prevalence rates could be seen. Organisations came to realise that measuring prevalence is not a simple task and currently there are few reliable accounts of prevalence (Toubia & Sharief, 2003). In May 2008 the 61<sup>st</sup> World Health Assembly established a resolution directly targeting FGC which Johansen et al. (2008) see as a benchmark

in the history of eradicating FGC. As the following excerpt shows, the resolution urged member states to intervene strongly to eradicate the practice.

The Sixty-first World Health Assembly [...] URGES all Member States:

- (1) to accelerate actions towards the elimination of female genital mutilation, including education and information necessary for full understanding of the gender, health and human rights dimensions of female genital mutilation;
- (2) to enact and enforce legislation to protect girls and women from all forms of violence, particularly female genital mutilation, and ensure implementation of laws prohibiting female genital mutilation by any person, including medical professionals;
- (3) to support and enhance community-based efforts to eliminate the practice of female genital mutilation, particularly ensuring men's and local leaders' participation in the process to eliminate the practice;
- (4) to work with all sectors of government, international agencies and nongovernmental organizations in support of the abandonment of the practice as a major contribution to attainment of the Millennium Development Goals on promoting gender equality and empowerment of women, reducing child mortality, and improving maternal health;
- (5) to formulate and promote guidelines for the care, particularly during childbirth, of girls and women who have undergone female genital mutilation;
- (6) to develop or reinforce social and psychological support services and care and to take measures to improve health, including sexual and reproductive health, in order to assist women and girls who are subjected to this violence (WHO, 2008, p. 22)

In recent years one has seen an increase in local, national and international initiatives designed to eradicate FGC (Toubia & Sharief, 2003). Several organisations have also started to evaluate the impact of their FGC initiatives (Johansen et al., 2008). In the 2000s a shift from viewing the practice as a purely biomedical problem to a cultural issue became evident. It was also acknowledged that approaches to the eradication of FGC should recognise its broader social context, rather than simply targeting health complications and trying to measuring results purely by drop of prevalence rates (Toubia & Sharief, 2003).

### **The Western Discourse on FGC and the African focus**

When looking at approaches addressing the need to end FGC, two views often come to the fore; the 'anti-FGM' view and the anti-'anti-FGM' view. Firstly, the anti-FGM view may refer to the "extreme feminist one [where] female genital surgery is meant to 'assure female sexual inferiority and thus, her submission to males'" (Hosken and Rafti as cited in Rafti, 1979, p. 19, parenthesis in original). Secondly, the anti-'anti-FGM' view insists that essentially the question to ask is whether outsiders should "make ethical judgements about behaviour in cultures different from their own" (Lewis, 1995, p. 17). Wade (2011) argues that such a binary understanding of FGC is illogical. She insists that there is a need to separate the destructive arguments from the constructive ones and in that way discard oversimplification, generalisations and stereotyping of

the phenomenon (Wade, 2011). Wade (2011) rather, views eradication of FGC as a dialogue between: (a) Universal norms and human rights; and (b) local values and cultural practices.

Wade (2011) has conducted a comprehensive literature review on the academic discourse on FGC from 1976 to 2005. The Western feminism that was dominant from the 1970s to the early 2000s is referred to as cultural imperialism by Wade (2011). Wade (2011) explains that Western feminist thought was in the 1970s and 80s tied to the idea that FGC was the symbol of extreme oppression of African women and that patriarchal structures were embedded in social structures all around the world. Wade (2011) found that the climate of condemning FGC and viewing African women as helpless continued up until the early 2000s. Critics of this dominant feminist view often argue that the practices of FGC are generalised and it is only the extreme forms of FGC that get attention - not the diversity of the phenomenon around the globe and within countries (Wade, 2011). Toubia (1988, p. 101, parenthesis in original) argues that Westerners have: "...portrayed [FGCs] as irrefutable evidence of the barbarism and vulgarity of underdeveloped countries, a point of view they have always promoted". Wade (2011) details that it is commonly FGC in Africa that is emphasised, although a diversity of forms of the practice is known to exist in most countries in the world, particularly in Asia (see Clarence-Smith, 2008; Merli, 2008; Putrani, 2008).

Wade (2011) further explains that understandings of FGC were influenced by the postcolonial turn in the mid-1990s. Postcolonial literature emphasises the diversity within a culture and promotes the view that culture is a constantly negotiated process. Abu-Lughod (1991), for example, breaks down the concept of culture altogether explaining that 'culture' creates others whilst it freezes the differences among individuals in a particular community. Postcolonial literature criticised approaches to FGC as euro-centric and promoting a view of culturally inferiority. It was argued that men and women in Africa are viewed as objects that need assistance, rather than as subjects owning social agency and free-will (Wade, 2011). Wade (2011) claims that this postcolonial critique dominated FGC literature from 1996 to 2005.

When trying to map the history and origins of FGC, Johnsdotter (2012) too found that most accounts on FGC were written by Europeans, not Africans, and she therefore argued that accounts of African female circumcision are in reality just as much about Europeans (Johnsdotter, 2012). She insists that as one is obviously dealing with Western-produced knowledge about an African phenomenon, it is inherently biased. She argues that as a result the history of FGC in Africa "tends to mirror 'us', and our preoccupations rife at certain points throughout history, rather than anything concrete it has to say about 'them'" (Johnsdotter, 2012, p. 107). Then again,



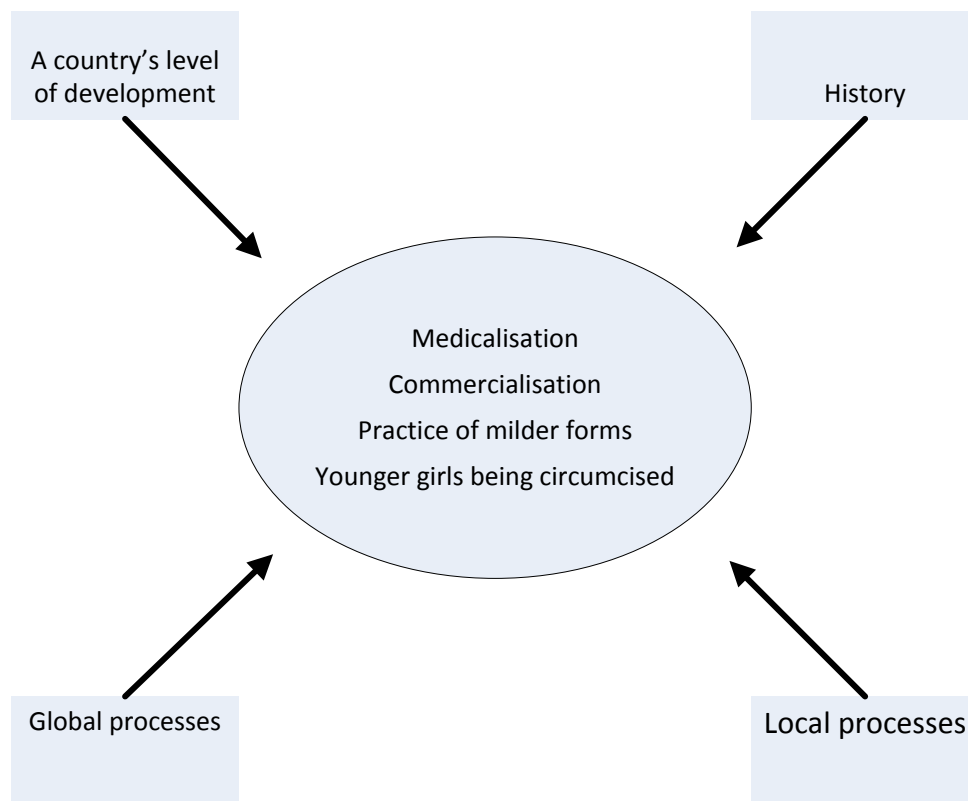
the postcolonial critique has in itself been criticised for generalising Western feminists as cultural imperialists. Indeed, it is a paradox that it is mainly Western-based scholars who write against the Western-feminist 'anti-FGM discourse' demonstrating that the FGC-discourse is much more diverse than often presumed (Wade, 2011).

FGC exists in many forms, in many different cultures and countries around the world. Different countries have different experiences and one size does not fit all. In the same token, ways of responding to and understanding the practice are plentiful, and accounts cannot easily be put into a clear-cut and universal explanation. The strongly generalised and binary understandings of the 'anti-FGM discourse' and the anti-'anti-FGM discourse' can inhibit a constructive and comprehensive debate on what FGC constitute and thus how it should best be eliminated (Johnsdotter, 2012; Wade, 2011). Wade (2011) insists that one needs to look at the nuances in the literature to reach a better understanding of FGC. Additionally, she explains, one has to acknowledge a diversity of worldviews and a diversity of FGC-practices in order to approach this topic.

### **Changes in practices of FGC at a global scale**

In the early 2000s it was questioned whether any progress had been made at all when it came to eliminating FGC. WHO (2011b) identifies the following general changes that can be observed at a global level: (1) The practice is declining; (2) there is a lowering of the age when girls are subjected to the practice; and (3) there is an increasing use of health-care providers to perform FGC (which is referred to as medicalisation of FGC). Talle (2010) adds that in countries where medicalisation is evident there is a trend towards milder forms of FGC. Furthermore she argues that commercialisation of the phenomenon is also apparent. By commercialisation she means that circumcisers have set prices for conducting the procedure, viewing it as a general commercial service, as opposed to the past when the procedure was embedded in non-market rituals. Overall, one may see a modernisation of the phenomenon where an old tradition is taken out of a 'primitive' sphere and into a 'modern' one due to a diversity of local and global processes (Talle, 2010). Modernisation of FGC practices as described by Talle (2010) is presented in figure 5 on the following page.

Figure 5: Modernisation of FGC practices (adapted from Talle, 2010)



As has been described, a natural way to analyse the impact of FGC initiatives is to measure the prevalence of the phenomenon. Three main challenges to measuring prevalence have been identified in the literature. Firstly, there have been few, if any, historical measurements of prevalence and thus a comparison of the past with the present is impossible. It was not until 1995 that baseline data initially began to be collected (Toubia & Sharief, 2003). Recently, however, the WHO has proposed two ways of measuring prevalence: One can either conduct a survey at two different times over a period of a few years, or one can identify changes by comparing the youngest and oldest age-group in a survey (WHO, 2011b). The second challenge to measuring prevalence rates is that if a physical examination is undertaken, it can be difficult to determine what, if any, types of circumcision have been carried out, as the tissue grows as the girl gets older (Johnsdotter, 2008). Thirdly, there are often local differences in the practice and therefore data cannot easily be compared across regions or countries in which FGC is practiced (Johnsdotter, 2008; Toubia & Sharief, 2003; Tiilikainen & Johansson, 2008)

As much of the campaigns in the 1980s and 1990s focused on the health risks of FGC one can now see FGC being subsumed in a process of medicalisation. Medicalisation of FGC refers to the increasingly high use of medical facilities, equipment and staff when the girl undergoes the

procedure and when seeking treatment of FGC-related health complications. Medicalisation is seen in relation to the past where unskilled staff and unclean equipment was often used (Talle, 2010). Medicalisation of FGC seems to be increasingly occurring across the globe (WHO, 2011b).

Kunnskapssenteret (2009) insists that there is too little evidence to make solid conclusions about the effectiveness of initiatives designed to eradicate FGC. Nonetheless, Kunnskapssenteret (2009) and Toubia and Sharief (2003) explain that it is possible to stop FGC and to improve current trends by: (1) Ensuring better reporting procedures of prevalence; (2) recognising a diversity of FGC practices in different geographical, cultural and political areas in the world; and (3) improving collaboration between organisations. What may be concluded, though, is that a diversity of practices continue, but with noticeable changes.

### **Male circumcision**

Although it is acknowledged that male circumcision is more common than FGC this thesis does not focus on male practices of circumcision (Wisdom, 2012). As was previously described, in many of the countries where females and males are circumcised there is usually one unifying word for the procedure. Nonetheless, it is implied in the use of the terminology of FGC and male circumcision that there are several fundamental differences between the two procedures (Talle, 2010). As opposed to FGC, it is argued that there are medical benefits with male circumcision (Talle, 2010). The WHO (2007) even recommends that African men should be circumcised so as to prevent the spread of HIV. These medical benefits, however, have received criticism from several health care professionals (Wisdom, 2012). George Denniston, who is the founder of 'Doctors Opposing Circumcision in the USA', claims that he has "never seen anything in medical literature as bad as [male] circumcision literature. A lot of it stands out to me as bullshit" (as cited in Collier, 2011, p. 1, parenthesis added). Although it is proven that there are severe harmful consequences of male circumcision, it has not been a priority area for scholars and the international community to further investigate (Talle, 2010). The controversies of male circumcision, conversely, do illustrate that it is, similarly to FGC, a topic embedded in many 'unknowns' related to cultural and medical beliefs.

### **Reviewing literature on FGC, eradication and Somaliland**

When reviewing the literature on Somaliland and Somalia it is often not clear whether the literature and statistics refers to Somalia or Somaliland. Usually Somalia is seen as the point of departure, but when reading the literature closer, it often turns out that the site of study is in North West Somalia, usually in the cities of Hargeisa, Burao or Boroma, which constitutes

Somaliland. This, of course, complicates a literature search on FGC in both Somalia and Somaliland.

In general, there is a lack of valid literature on FGC and reproductive health in Somalia, which may be due to the nature of the research. It can often be challenging to gain access to the field, both as Somaliland is politically unstable and because reproductive health, and particularly FGC, is considered a culturally and medically sensitive issue (Bisset et al., 2010; Sorbye & Leigh, 2009). Quantitative research and statistics in Somalia can be contested as population data is often lacking, of poor quality, and is continuously outdated. Moreover, the nomadic lifestyle of most Somalis makes it a significant challenge to present data and statistics that are both valid and representative of the total population (Linard et al., 2010). Even those studies that have conducted country-wide surveys often refer to Somalia as including Somaliland and Somalia. It seems hard to generalise statistics as Somalia is a country without government in chronic war, while Somaliland has a government and is functioning relatively well (Bradbury, 2008). Another issue related to statistics on Somaliland is that even though Somaliland has a government it is not internationally recognised as an independent country. Therefore there are clear limitations to keeping track of country measurements, particularly in the rural areas (Linard et al., 2010).

In addition, rather than being purely academic, most of the literature on reproductive health care and FGC in Somalia and Somaliland consists of reports produced by organisations such as evaluations of an organisation's programmes. These reports can be limiting as they are biased towards the functional aims, mission and principles of the sponsoring organisations. There is also a lack of peer-reviewed academic literature on Somalia in general. Perhaps this is why there is a lack of consistency across the literature on Somalia (Mazzilli & Davis, 2009). Due to the lack of literature available when outside of the field, effort was made throughout the fieldwork period to collect reports and literature from different organisations. The following is an account of the review of FGC eradication in Somaliland based on some of the documents collected during the fieldwork as well as literature found before and after.

### **History of eradicating FGC in Somalia and Somaliland**

In March 1977, before Somaliland declared its independence from Somalia, Edna Adan Ismail, who was married to the former Prime Minister of Somalia (1967-1969) Mohamed Haji Ibrahim Egal, publicly declared the campaign to eradicate pharaonic circumcision from all of Somalia during a meeting to establish the Somali Women's Democratic Organisation. Due to the nature of the meeting, female leaders from all of Somalia were present. Ismail intended that these leaders would gain useful knowledge that could be brought with them in future FGC-work all over

Somalia (Ismail, 2009). Ismail continued to lobby to eradicate FGC after this meeting. She attended and denounced FGC at many conferences and seminars within Somalia and abroad, including in Khartoum, Copenhagen, Dakar, Lusaka and Egypt.

Siad Barre was the President of Somalia in the period 1969-1991. At that time Somalia was linked with the Soviet Union (USSR) and Siad Barre developed his own brand of socialism which he called “Scientific Socialism” (Lewis, 2002, p. 206). His programme contained a literacy and gender rights program where FGC was mentioned as a policy area (Abby & Mahamoud, 2005). In the late 1980s Ismail lectured nursing students at the University of Mogadishu where pharaonic circumcision was included in the curriculum and graduates gained knowledge on the harmful consequences of FGC (Ismail, 2009). The government continued to conduct research on the complications of pharaonic circumcision proposing to eradicate it due to health-related and religious reasons. The Somali Women’s Democratic Organisation joined the Italian Association for Women and Development in 1989 and proposed a campaign with a health focus in Somalia, believing that a human rights approach would not get the intended results (Ismail, 2009).

In 1991, however, Siad Barre was overthrown and a period of chronic conflict ensued. At this time the organised campaigns against FGC collapsed (Ismail, 2009). In the years from 1988 to 1997 Ismail was outside of Somalia due to war, but continued to work together with other activists to pressure the WHO, UNICEF and other human rights organisations to focus on FGC (Ismail, 2009). Somaliland declared its independence from Somalia in 1991. However, it was not until 1997 that the revival of initiatives designed to eliminate FGC took place. Ismail, who was then a WHO representative in the Republic of Djibouti, was asked to return to Somaliland to attend and denounce FGC at the first seminar to revitalise efforts to abandon the practice. After this seminar several NGOs and women’s groups initiated and continued their own campaigns to eradicate FGC. In addition, a national committee and a regional taskforce were founded to develop policies addressing FGC issues (Ismail, 2009).

### **FGC practices in Somaliland**

A report published by the United Nations Population Fund and the World Bank (Diop & Ba, 2004) explains that in the past FGC was undertaken as an initiation ritual into womanhood. However, currently, they claim, this is no longer the case as girls are circumcised when they are younger, between the ages of four to eight years old. Because it is so integrated in the culture, Talle (2010) explains that culture in itself may be the single most important reason one decides to circumcise. Diop and Ba (2004) explain that there are three life stages for a female related to the pharaonic circumcision: The time of circumcision; at the wedding night; and when in labour. If

the girl has undergone the pharaonic circumcision she will have to be opened for sexual intercourse at the night of the wedding, either by her husband using force or by a person (family member, circumciser or health worker) cutting her. At the time of labour women will have to be completely opened, usually by a health worker or circumciser (Diop & Ba, 2004). The use of force by husbands is reported to be more common in South-Central Somalia than in Somaliland. Talle (2010) claims that in Somaliland a more severe form of FGC is practiced than in South-Central Somalia. As opposed to practices in Sudan, however, it is not common that the female is re-infibulated (i.e. the vaginal walls are re-fused) after giving birth (Talle, 2010).

### **Current initiatives designed to eradicate FGC in Somaliland**

Currently, there are many organisations working on FGC issues in Somaliland and most of these are based in Hargeisa. The following is an account of the literature found on FGC-initiatives in Somaliland and Somalia keeping in mind the limitations of the literature.

Diop and Ba (2004) argue that several surveys conducted by the United Nations Population Fund and the World Bank in both Somaliland and the semi-autonomous state of Puntland in the beginning of the 2000s, show that FGC is almost universally practiced in both urban and rural areas. In these surveys about 90 per cent of women report that they have undergone pharaonic circumcision. Another study referred to in the same report concluded that the level of education, socio-economic background and settlement did not have significant influence on whether or not the custom was practiced (as cited in Diop & Ba, 2004).

Diop and Ba (2004) insist that behaviour change is crucial in eradicating FGC and propose a behaviour change model based on respect and understanding of Somali culture. The proposed model is based on five different stages: pre-contemplation; contemplation; preparation for action; action; and maintenance (Diop & Ba, 2004). Throughout the time of behaviour change, however, there is always a risk of failure owing to community repercussions (Diop & Ba, 2004). Further, Diop and Ba (2004) identify two main ways to implement FGC initiatives in Somalia. The first is to grant funding earmarked for FGC initiatives. This is claimed to be challenging as funding usually only lasts for one to two years, complicating both short and long-term responses. The second way is to grant longer-term funding, where FGC is integrated into other programmes run by an organisation, for example, human rights programmes, gender programmes, or safe-motherhood programmes (Candlelight, 2008; Diop & Ba, 2004). Overall, there seems to be a focus on pharaonic circumcision in the initiatives. Sunna circumcision seems to be explained as an alternative to pharaonic circumcision (Diop & Ba, 2004). Gulaid (2008) explains that FGC

eradication activities mainly focus on awareness-raising and providing alternative skills to circumcisers.

### **Changes in practices of FGC in Somaliland**

Diop and Ba (2004) found that very few organisations actually address the underlying causes behind the continuation of FGC, and most are approaching the issues fairly superficially. They take an evaluation report on FGC initiatives conducted by UNICEF in 2003 as an example. The report concluded that although there are several initiatives in place, sustainable and strategic initiatives are lacking (Diop & Ba, 2004). Diop and Ba (2004) argue that as behaviour change is looked upon as a long-term process, sustainable work is required at a community level. They give an example of a three-day breast-feeding campaign in which FGC awareness activities were integrated. They argue that the campaign can only give results if there is a continuity of relationship between the organisation and individuals in the community. However, in maintaining initiatives to eradicate FGC there will always be challenges to sustainability such as human and natural emergencies, no resources and lack of political will and commitment. Therefore strategic initiatives focusing on the holistic context of FGC as well as sustainable campaigns are needed (Diop & Ba, 2004).

In June 2011 the Somali Red Crescent Society conducted a preliminary evaluation report of its female genital mutilation/cutting (from now referred to as FGM/C) programme in Somaliland from 2009 to 2014 (Ansorge, 2011). The researcher received this report during the fieldwork period. The Somali Red Crescent Society had its pilot project on FGM/C in 2003 and at the time of the report the programme existed in all regions of Somaliland. There are three components of the programme: To raise awareness to prevent potential circumcisions; to provide treatment to those already suffering from the consequences of FGC; and to provide training and alternative incomes to circumcisers (Ansorge, 2011). Both in-depth interviews and a focus group discussion were conducted with staff and volunteers at the different sites of the programmes, mainly in Maternal Child Health clinics (from now referred to as MCHs), were conducted as well as with stakeholders working on FGC. The findings of the interviews and focus group discussion showed that there was a shift from practicing pharaonic to sunna circumcision. It seemed that sunna was now widely practiced. The report also found that some people claimed they would not circumcise (Ansorge, 2011). Ansorge (2011) further stated that circumcisers had continued their practice once the financial support stopped and proposed that financial support to circumcisers is not useful in eradicating the phenomenon (Ansorge, 2011). However, it was found to be useful that traditional birth attendants (from now referred to as TBAs) who also practiced circumcision

were offered medical training and were encouraged to condemn FGC. Training of midwives to handle complications of FGC was found to be successful, and further trainings were encouraged (Ansorge, 2011). One of the challenges of FGC-work, however, was lack of documentations of programme activities and thus a lack of programme transparency (Ansorge, 2011). A collection of data on prevalence of FGC complications was also highly recommended (Ansorge, 2011). Lastly, the report pleads for better coordination and collaboration between organisations working on FGC (Ansorge, 2011).

Although some studies claim changes in the practice, a survey with data from 2002 to 2006 supposedly conducted by physical examination and oral interviewing in the out-patient department at the Edna Adan hospital in Hargeisa, concludes that 97 per cent of patients had undergone FGC. It was found that 99 per cent of those that had undergone FGC had undergone pharaonic circumcision (Ismail, 2009). Further, 62 per cent said they would perform FGC on their daughter, while 37 per cent said they would not. Out of those 62 per cent that wanted to perform FGC on their daughter 92 per cent reported they wanted to do the sunna type, while six per cent were in support of the pharaonic circumcision. A survey conducted in 2008 shows that 80.9 per cent of the daughters of the respondents (aged 18 to 43) had undergone pharaonic circumcision, while 19.1 per cent had undergone sunna circumcision (Baruud, 2008). There are obviously contradictions in these studies, with the latter claiming a higher incidence of sunna circumcision. Nonetheless, there seems to be a shift to sunna circumcision.

### **FGC in the Somali exile**

This thesis does not specifically look into exile habits, but acknowledges that there are different practices of FGC in the diaspora. Several studies report that pharaonic circumcision has been abandoned among Somali immigrants living in Oslo and London (Gele, Kumar, Hjelde, & Sundby, 2012; Talle, 2010). According to Talle (2010), there is still a noticeable amount of individuals that support sunna circumcision. However, she further argues that criminalisation of the practice in several of the host countries functions as a preventative measure with more claiming to abandon the practice due to it being illegal. The practices of FGC in exile and in Somaliland differ and both are constantly changing (Talle, 2010).

### **Justification of research enquiry**

Although much of the knowledge on FGC, particularly in Somaliland, is bordering on the unknowable, there is indeed knowable knowledge on the topic. It is a fact that there is near universal international agreement that FGC should be eradicated and there is also knowledge on changing practices of FGC. Despite the continuation of the practice, and questionable data



available, there is evidently a change in how FGC is perceived in Somaliland. However, there is no consensus on exactly what change has been made and what FGC currently constitutes. The available knowledge on FGC is predominately produced in 'the West'. Therefore 'progress' made in eradicating FGC is far from value-free, and the concept needs to be further explored. If one does not understand how FGC is currently perceived, and how approaches to eradicate it are constructed, it is hard to imagine that eradication of FGC is possible. Few studies look into current practices and understandings of FGC, particularly in Somaliland. This study will therefore explore how FGC is perceived in Hargeisa, Somaliland. As there seems to be international consensus that FGC must be eradicated, it seems feasible to look at how current practices of FGC is perceived assuming that these perceptions are intrinsically linked to efforts to eradicate FGC. This study's aim is to produce an understanding of how FGC acts out in a socially and culturally constructed world, insisting that abandonment depends on perceptions of what FGC constitutes.



## **Chapter 4: Research Design**

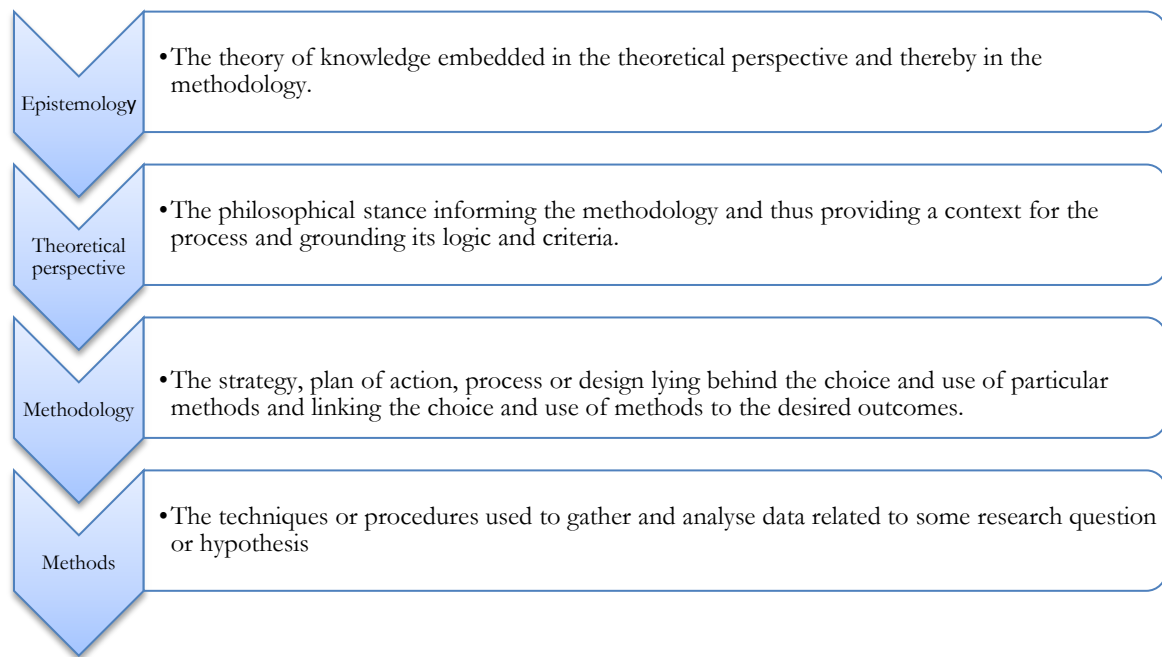
A research project usually starts off with an interest in some real-life phenomenon, often a problem. It is generally this problem that guides the further research process and so research questions emerge (Crotty, 2009). On top of that, different ways of knowing steer how the phenomenon is understood and thus how one make sense of the issues. This chapter aims to demonstrate how this research project has come about and to explain the methods used to explore FGC and FGC abandonment in Hargeisa.

Firstly, the chapter will present the epistemology, theoretical perspective and methodology informing the research question and research methods. Secondly, it will account for the methods chosen and present how the data were collected and analysed. Ethical considerations will thirdly be discussed. Finally, the limitations and strengths of the research design will be discussed. This includes a discussion on the role of the researcher in social research and how this role influences the data on FGC.

### **Research Design**

Crotty (2009, p. 1) points out that the terms ‘methods’, ‘methodology’, ‘theoretical perspective’ and ‘epistemology’ often “appear more as a maze than a pathway to orderly research”. He therefore offers a comprehensive schema for using the four terms as can be seen in figure 6 on the following page. In this research project Crotty’s (2009) understanding of the four terms is used. It should also be made clear at the outset that the researcher views research as an emerging *process* in which each stage – research design, data collection, analysis and producing the final report – are interlinked and inform one another (Davidson & Tolich, 2003).

**Figure 6: Crotty's (2009) schema for the foundations of social research**



## Epistemology

FGC is increasingly being conceptualised as much within the social sciences and humanities as within the biomedical field (Ingstad, 2007). As a practice embedded in social and cultural meanings, it is imperative that these are meanings are examined and that campaigns to eradicate the phenomenon are based on an awareness of its social and cultural significance. This research is therefore guided by a constructionist epistemology, which emerges from the recognition that all knowledge is to some extent negotiated socially. Crotty (2009, p. 42) explains that constructionism is the philosophical view that “all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context”. In the Somali context, for example, Helander (1990) argues that although health care delivery is ostensibly based upon scientific, medical knowledge, people make use of the health care services that seem most relevant to them and reject what they see no value in (Helander, 1990, p. 2). In this way, Helander (1990) illustrates the complex ways in which interventions designed to change behaviour play out in a world that is, beyond doubt, constructed socially.

FGC and FGC eradication will therefore be examined foremost as a social process, rather than purely technical, administrative or biomedical processes. It is, arguably, not the lack of biomedical knowledge that inhibits eradication of FGC, but rather the social structures in which they are embedded (Crotty, 2009; Talle, 2010). Therefore the emphasis of this study will be on the ways in which individuals, institutions, ideas and understandings interact in a particular setting to facilitate

or impede abandonment of the practice. A key implication of constructionism is that the researcher herself is embedded in the same social processes in which meaning is constructed. The researcher's position and role in the construction of knowledge is therefore examined later in this chapter.

### **Theoretical perspective**

A recurrent emphasis throughout the research project has been that research phenomena must be located in their broader context of cultural, social, political and economic 'development'.

Development theories are often contradictory, but by looking at them as paradigms in a constantly evolving conversation, development theories acknowledge that change happens in complex ways (Peet, 2005; Pieterse, 1998; Rist, 1997).

The theoretical perspective of this research project initially drew upon key elements of feminist theory that serve to highlight the ways in which social norms and knowledge act in a particular setting to include or exclude certain social actors. Feminist enquiry has greatly influenced the way issues of power are understood. Consequently such an inquiry can help understand how all forms of inequality (including cultural difference, development and gender) are perpetuated. In the process of scrutinising social structures, feminist theory positions social change as highly possible and is thus crucial in understanding abandonment of FGC (Alice, 2003; Gottfried, 1996; Ramazanoglu & Holland, 2003).

In the initial stages this study was also strongly influenced by the theoretical work of anthropologists such as Paul Farmer who has developed an understanding of medical systems as cultural systems and is a strong proponent of the concept 'structural violence' (Saussy & Kidder, 2010). The concept criticises the "formal acceptance of 'the way the world is'", and builds on history and political economy as important determinants of social inequality and poverty (Saussy & Kidder, 2010). By looking at the practices of FGC as structural violence one can view social structures and institutions as important perpetuators of the phenomenon of FGC and of its abandonment (Saussy & Kidder, 2010).

After data collection the work of the philosopher Michel Foucault emerged as a useful theoretical lens through which to make sense of research participants' understandings of FGC. His work provides a valuable toolkit for analysing social and cultural organisation as it offers an alternative way of thinking of what is conceived as 'reality' (Burrell, 1988). Foucault argues that how we understand ourselves and others, at any historical moment, is defined by larger structures of knowledge (discourses) which enable power to operate on human subjects. The notion of

discourse moves away from seeing culture as a single set of ideas to examine how knowledge and power interact to create human subjects and social organisation (Foucault, 1980; Merquior, 1985). Although human agency is to some extent ignored in Foucault's work, his understanding of reality is useful in looking into FGC in a culturally sensitive way. It recognises the hidden or unintended ways power operates through discourse, highlighting how 'we' understand 'us' and 'them', while at the same time questioning understandings of Western modernity as the best way forward for global society (Bodley, 2005; Smart, 1982).

## **Methodology**

The main assumption of this research is that FGC, and efforts to eradicate it, must be seen in their socio-political context to be properly understood. Therefore a qualitative approach is proposed. A qualitative methodology can be defined as a research strategy focusing on processes and actions in everyday life. Further it views words, behaviours, actions and norms important data. An inductive or interpretive approach is employed in data analysis. Lastly, a qualitative methodology emphasises description and understanding over prediction (Bryman, 2004; Ezzy, 2002; Rothe, 1993). Following Fangen (2004) this research also employs an emergent design which values what the field teaches the researcher by enabling the research to evolve as new information comes to light. An emergent approach is useful in that it provides flexibility of design throughout the research cycle. The next section demonstrates how an emergent design has been used to arrive at the research question for this project.

## **Arriving at the research question**

The literature on Somalia and Somaliland is often inconsistent and it is therefore difficult to gain a solid understanding of the situation based on the literature alone. This research therefore began with a broad area of interest and then used the initial fieldwork to narrow this down to a specific research question. In the initial stages this project attempted to map and evaluate the use and needs of reproductive health services amongst IDPs in Hargeisa. Thus, the first qualitative interviews were conducted with representatives of agencies working in this area (see appendix 1 for interview guide).

As the initial data collection proceeded it became clear that the term IDP in the Somaliland context can be used to refer to a diverse number of individuals in society, such as those living in an IDP camp, those integrated into the host community, nomadic peoples and economic immigrants from Ethiopia and Djibouti. In fact, one can claim that every Somalilander has been displaced at some point in their lives (Abby & Mahamoud, 2005). Furthermore, health problems and access to health services were not found to be significantly different for IDPs than for other

sections of society. The scope of the research was therefore narrowed to focus on reproductive health.

In this initial stage of the research a topic that emerged strongly from interviews was FGC. As has been discussed in the previous chapter, there is little reliable data available on FGC in general in Somaliland. However, several of the informants at this point claimed that FGC has a significant negative impact on women's health, as the practice can lead to, among other things, uterine prolapse, complications during delivery, heavy bleedings, fistula and malnutrition of both mother and child (due to the belief that the mother should not eat during pregnancy so that the baby is small enough to be able to be born). Given the indications of an approximate 95 per cent prevalence rate of FGC in Somalia, and keeping in mind the claim that FGC has no medical benefits, it was assumed that FGC was a crucial part of women's reproductive health in Hargeisa. (Black, 2010; WHO, 2000).

It was therefore seen as feasible that the rest of the data collection should focus on how FGC is perceived in Somaliland. The interview guide was at this point changed to reflect this (see appendix 2). It was decided that all data would be collected in Hargeisa due to time, financial and security restrictions. At this point it was considered useful to get as diverse perspectives as possible. Research participants were therefore recruited from as many different social settings as possible. The following is an outline of the final research objective, aims and data collection methods. This is in turn followed by a more detailed description of the research methods employed.

## **Research objective**

The overall objective of the research is to:

- Explore how FGC, and the abandonment of FGC, are perceived in Hargeisa

To do this the following aims and data collection methods were used:

Aim 1: To explore and map current work done on abandoning FGC in Somaliland. To achieve this aim the following methods were used:

- a. Literature review
- b. Interviews with representatives of different organisations working to eradicate FGC

- c. Participation in a governmental workshop, namely 'Inter-ministerial dialogue and consensus for the development of Ministerial statement on FGM/C abandonment' (from now referred to as 'FGM/C-workshop')
- d. Participation in a workshop initiated by the UNICEF, namely 'Mapping child protection systems in Somaliland: Validation workshop' (from now referred to as 'UNICEF-workshop')

Aim 2: To explore how FGC and abandonment of FGC are perceived by those not working directly to abandon FGC. To achieve this aim the following methods were used:

- a. Qualitative interviews with people that do not directly work to eradicate FGC: Health care workers, TBAs/circumcisers, lay women and men, religious scholars (from now often referred to as 'lay' people)
- b. Collection of publically available material related to eradication of FGC

Aim 3: Analysing and validating the data: Observation. To achieve this aim the following methods were used:

- a. Informal conversations
- b. Field-notes made throughout the fieldwork
- c. Conversations with the research assistant

## Methods

The fieldwork was conducted in Hargeisa, Somaliland, from 8<sup>th</sup> September to 14<sup>th</sup> December 2011. The following is a layout of how the data were collected.

### *a. Literature review*

The literature search was conducted before, during and after the data collection period depending on emerging research themes. Databases such as JSTOR, PubMed and AnthroSource have been used. In addition, the search tool 'Google Scholar' and a subscription to weekly alerts on relevant themes were used. The websites of several organisations, such as the United Nations institutions, have been used to search for reports and projects. Reference lists of relevant books and academic articles have also been used to find further references.

In addition, documents such as reports and research summaries from several organisations were collected in Hargeisa during the data collection period. Most of these documents have not been



made available outside of Hargeisa. These are therefore used in both the findings and the discussion chapter.

*b. The research participants*

The first part of the data collection consisted of interviews with representatives of organisations working on reproductive health issues or on FGC matters. 16 semi-structured in-depth interviews were undertaken with a total of 22 individuals. Table 2 below presents an overview of these research participants. The first four interviews were used for narrowing down the topic to FGC. As can be seen in the table, a number of interviews were conducted with more than one interviewee. This was not planned in advance by the researcher, and may have influenced how participants spoke about the issues. This was particularly apparent in one interview (organisation 6) where one research participant dominated and it was difficult for the researcher to include the two other participants. Nonetheless, it is believed that in all these interviews a different kind of knowledge was presented as research participants sometimes corrected each other or disagreed on issues being discussed.

**Table 2: List of interviews with research participants from organisations working to eradicate FGC**

REFERENCE	AGENCY	DATE	NUMBER OF PARTICIPANTS
<b>Organisation 1</b>	Multilateral agency	20.09.2011	One
<b>Organisation 2</b>	Government representative	25.09.2011	One
<b>Organisation 3</b>	NGO	30.09.2011	One
<b>Organisation 4</b>	NGO	04.10.2011	Three
<b>Organisation 5</b>	INGO	09.10.2011	One
<b>Organisation 6</b>	Medical facility	20.10.2011	Three
<b>Organisation 7</b>	INGO	23.10.2011	One
<b>Organisation 8</b>	NGO	23.10.2011	One
<b>Organisation 9</b>	Multilateral	23.10.2011	One
<b>Organisation 10</b>	Medical facility	24.10.2011	One
<b>Organisation 11</b>	INGO	24.10.2011	Two
<b>Organisation 12</b>	INGO	24.10.2011	One
<b>Organisation 13</b>	NGO	25.10.2011	One
<b>Organisation 14</b>	Government representative	05.11.2011	Two
<b>Organisation 15</b>	NGO	20.11.2011	One
<b>Organisation 16</b>	INGO	21.11.2011	One

The second part of the data collection focused on the views of several social actors and their perceptions of FGC and the abandonment of the practice. It was envisaged that this part of the research would highlight some of the broader issues of FGC and the global campaign to eradicate

the practice. For this part of the data collection a female research assistant was hired. The research assistant was a native Somalilander in her mid-20s and worked as a nurse in one of the hospitals in Hargeisa. She had lived in the Middle East for several years during her childhood and youth, and had moved back to Somaliland in 2005. Since she had been attending an English-speaking school in the Middle-East, her English skills were of good quality. In addition to English and Somali, she spoke Arabic.

Table 3 provides an overview of the research participants for this part of the research. Initially, the researcher sought to understand FGC as a medical phenomenon, and therefore health workers were targeted. However, as new themes emerged, several people from outside of the health care sector were recruited. Thus 16 qualitative interviews were made with different actors including health workers, TBAs (who also claimed to circumcise females), females working in beauty salons, a religious scholar and two men in their twenties. At this stage of the data collection the research assistant was used in all interviews except the interview with the religious scholar. This interview was conducted in English.

**Table 3: List of interviews with research participants not directly working to eradicate FGC**

REFERENCE	PLACE OF INTERVIEW	GENDER	AGE <sup>2</sup>	OCCUPATION	DATE
<b>Midwife 1</b>	Hospital 1	Female	28	Midwife	31.10.2011
<b>Midwife 2</b>	Hospital 1	Female	38	Midwife	01.11.2011
<b>Nurse 3</b>	Hospital 1	Female	Early 20s	Nurse	03.11.2011
<b>Nurse/midwife 4</b>	Hospital 1	Female	Early 20s	Nurse/Midwife	03.11.2011
<b>TBA 5</b>	MCH	Female	47	TBA/circumciser	12.11.2011
<b>TBA 6</b>	MCH	Female	More than 50	TBA/circumciser	13.11.2011
<b>Nurse/midwife 7</b>	Hospital 2	Female	Approx. 30	Nurse/midwife	15.11.2011
<b>Housewife 8</b>	MCH	Female	Approx. 50	Housewife	20.11.2011
<b>Housewife 9</b>	MCH	Female	More than 50	Housewife	20.11.2011
<b>Beautician 10</b>	Beauty Saloon 1	Female	27	Beautician	22.11.2011
<b>Beautician 11</b>	Beauty Saloon 1	Female	Early 20s	Beautician	24.11.2011
<b>Beautician 12</b>	Beauty Saloon 1	Female	27	Beautician	24.11.2011
<b>Beautician 13</b>	Beauty Saloon 2	Female	Early 30s	Beautician	26.11.2011
<b>Man 14</b>	Restaurant	Male	23 or 24	Banker	27.11.2011
<b>Religious scholar 15</b>	Restaurant	Male	Unknown	Religious scholar	01.12.2011
<b>Man 16</b>	Restaurant	Male	25	Student	02.12.2011

<sup>2</sup> When the age is given as an approximate, the research participant did not know their exact age and were therefore asked approximately how old they were.

*c. The recruitment of research participants*

The two groups of research participants were approached and recruited in slightly different ways.

For interviews with the representatives of organisations working on FGC the researcher had been provided with a list of contact persons working on reproductive health care in Somaliland from her co-supervisor who had previously worked in the country. Contact was made with these people either over phone or e-mail. Further, 'snowballing' was an important part of the recruitment of these participants. This means that at the end of each interview the person interviewed was asked whether he or she knew someone that would have interest in participating in the research. In this way, the researcher was either introduced to other potential research participants or provided with further contact details. The only criteria for selecting participants were that they had work experience related to the topic and were willing to talk about it. When contact was made, the potential research participants were informed about the background of the researcher, the research project and asked if they were willing to be interviewed for about one hour. If contacts agreed to participate, a time and place for the interview was agreed upon.

In the interviews with the research participants who did not directly work to abandon FGC the researcher and the research assistant visited different public arenas for recruitment of research participants. These arenas were chosen based on emerging research themes. The arenas include: Two hospitals, two beauty salons and a MCH (maternal child health clinic). In each of these places the researcher or research assistant introduced the research to the director and asked if any of the staff members would be interested in participating. In this way the researcher and research assistant were introduced to potential research participants. These participants were in turn told about the research and asked if they were interested in participating. It was then agreed when and where the interviews could take place. At the end of each interview the research participant being interviewed was also asked if he or she knew someone else the researcher could approach for participation in the research. In this way the two housewives, who were family members of some of the patients at the MCH, were recruited. The religious scholar was recruited through a research participant who was a representative of an organisation working eradication of FGC. One of the men was recruited through acquaintances of the research assistant. The other man was an acquaintance of this man and recruited through him. The same procedure for informing about the research project was followed in these five interviews.

*d. The semi-structured in-depth interviews*

Every interview was prepared in advance, and the questions and topics were tailored according to what the researcher and/or research assistant knew about the organisation or person beforehand. The interviews were structured according to certain pre-determined themes. However, more open-ended questions were also used to enable research participants' own understandings and opinions to emerge. See appendix 2 and 3 for the two interview guides that were used for the two groups of research participants.

All of the 16 interviews with organisation workers were conducted in English by the researcher. The place of interview was at their workplace during work hours. A recorder was used in all the interviews, except two. Interviews lasted from half an hour to two hours. All recorded interviews were transcribed verbatim by the researcher as soon as possible after the interview (between 1-3 days after). For the two interviews that were not recorded, extensive notes were taken throughout the interview and a summary was written immediately after the interview. Some of the research participants were contacted for follow-up questions.

The interviews with the 'lay' people took place in a location suggested by the research participants, which mostly ended up being the place they worked. The interviews were conducted in a private room or a private part of the location. Only the researcher, research participant and research assistant (except in the interview with the religious scholar) were present. Some of the interviews were interrupted by someone entering the room, but every interview was continued and finished. The two housewives were invited to come to the MCH by the TBA who recruited them, and the interviews were therefore conducted at the MCH. All male participants were asked to meet in a restaurant for the interview. The reason for conducting the interviews in a restaurant was that the research assistant suggested it was more appropriate to interview men in such a social setting, keeping in mind the topic of the interview, rather than at their workplace. The interviews lasted from half an hour to two hours. A voice recorder was used in all interviews except one. In this interview both the research assistant and researcher took extensive notes, and wrote a summary together afterwards. In all these interviews an interview guide was used by both the researcher and the research assistant. The research assistant briefly translated throughout the interviews so both the researcher and research assistant were able to ask follow up questions. The use of the interview guide and the analysis of the interviews will be further discussed later in this chapter.

Beverages and snacks were brought to all interviews. No other costs were covered for the research participants.

*e. Translation*

The research assistant translated the interviews as soon as possible after the interview finished. The recorded interviews were transferred to the researcher's computer and the research assistant then translated these verbatim and orally with the researcher present. These translations were recorded and later transcribed verbatim by the researcher. As the interviews were recorded and short translations were done throughout the interview the researcher compared these translations to those done after the interview. These translations were to a large extent consistent, with the verbatim translation providing an in-depth translation of the interview. In addition, one of the interviews were conducted in Arabic, which the researcher has knowledge of, and the researcher found the translation of this interview adherent with what she understood of Arabic from the interview itself. The fact that the translation was done orally and with the researcher present allowed the researcher to ask the research assistant to explain certain themes or topics discussed in the interview in order to better understand and contextualise the findings.

*f. Workshops*

The researcher was invited by one of the research participants to attend a two-day workshop called 'Inter-ministerial dialogue and consensus for the development of Ministerial statement on FGM/C abandonment' on 28th-29th November 2011. At this workshop, three different ministries came together to make a common statement on eradication of FGM/C. The ministries represented were: The Ministry of Labour and Social Affairs, the Ministry of Religious Affairs and the Ministry of Health and Labour. The workshop consisted of presentations, group discussions and group work and was conducted in Somali only. However, the researcher was granted permission by the Ministry of Labour and Social Affairs (who led the workshop) to use a voice-recorder to record the proceedings and to use this as part of the project. Recordings were later translated by the research assistant, who did not attend the workshop. In addition, a representative from the Ministry of Health and Labour translated for the researcher at various times throughout the workshop and the researcher took notes and wrote summaries of these after the workshop ended. Throughout the workshop the researcher only observed and did not present her opinions in any way.

The researcher was also invited to join a workshop held by UNICEF called 'Mapping child protection systems in Somaliland: Validation workshop' on 4 - 6<sup>th</sup> December 2011. The workshop consisted of group-work, presentations and policy recommendations. Participants included representatives of the government, NGOs, INGOs and bilateral and multilateral agencies. Most of the workshop was conducted in Somali, although there were some English

speaking presentations throughout. This workshop was not recorded, but notes were taken and the hand-outs during the workshop gathered. Some of the Somali presentations were translated for the researcher by workshop participants. The researcher was granted permission to use the notes and hand-outs as a part of the research project.

*g. Collecting FGC material in the public sphere*

As this research project is looking into perceptions of eradication of FGC it seemed natural to collect material used in FGC campaigns. The researcher took photos of posters publicly available in health facilities and collected materials used by organisations (such as a t-shirt and booklets). The research assistant collected newspapers for a period of one week, but nothing was found on FGC. She also listened to a health programme on the radio every morning for a month but was unsuccessful in finding any information about FGC.

*h. Observation and analysis throughout the fieldwork period*

A purpose of doing observation research is to reflect upon one's own positionality and pre-understandings to improve the data collection methods and to later analyse and code the data produced. Coding of field-notes can help highlight data that may not have been considered previously and it may inform an emerging research problem (Davidson & Tolich, 2003). The researcher made use of field notes, informal conversations and conversations with the research assistant to better reflect on and inform the research findings. Notes were also taken on thoughts and impressions of the research setting throughout the days in the field. All of these observations were used for analysing the material during the fieldwork and making necessary changes to the questions and themes in the interview guide throughout the time in the field.

Notes were taken while transcribing and listening to the recorded material of the interviews with representatives of organisations. The knowledge gained by doing this was brought into the questions asked in subsequent interviews. In this way some themes, for example, what the partners and funding of organisations were, were excluded, while new themes were included such as how coordination between organisations working on FGC was perceived. Additionally these notes allowed for the researcher to reflect on how the interview in itself was conducted. Particularly she allowed for more time to listen and probe which resulted in a more open approach to emerging themes. The researcher also allowed more time for introducing herself in order to let the research participant better comprehend what the research project involved and how they could contribute to it.

Several informal conversations about people's opinions on FGC and eradication were written down. The reason these conversations were not 'proper' interviews is because they took place in an ad hoc manner when the researcher was talking about her research project to people she met during the fieldwork period. Eight conversations in total were written down and considered as valuable to the research project. These include two Somalilanders who had returned from the diaspora, several expatriate medical staff working in Hargeisa and some representatives of organisations or the government who the researcher met after some of the formal interviews and during the workshops. The FGM/C-workshop and UNICEF-workshop were helpful in validating the findings of the data gathered in interviews.

It was also realised, particularly in the interviews with the people not directly working to eradicate FGC, that by asking if the research participants had any questions for the researcher at the end of the interview a more relaxed atmosphere was experienced. Often the research participants at this point went into depth on issues that had already been discussed, or introduced new ones. The same was experienced during some informal conversations after the recorder was turned off. These were written down as soon as possible after the interview. The informal conversations took place in a more relaxed and informal way than the interviews and therefore some of the opinions shared were different to the ones collected in interviews. All the informal conversations thus provided a further understanding of the environment in which FGC and FGC abandonment take place.

After each translation, the research assistant and researcher had a conversation for about an hour each. During these conversations the research assistant and researcher discussed how the interview was conducted, what was good and what could be improved for next time. This conversation was voice-recorded and transcribed for further analysis. Continuously throughout the data collection period the researcher and research assistant talked through different techniques that identify a qualitative interview such as probing, pausing and not simply reading out the interview guide as a quantitative questionnaire. Additionally, the researcher spent considerable time during these conversations to explain why certain questions were asked, discussing importance of informed consent and confidentiality and emphasising that the research assistant needed to separate her interpretation and pre-understandings when communicating with the research participants in order to avoid leading questions during interviews and to prevent as much bias in translation as possible. It became apparent to the researcher that, as the research assistant was opposed to FGC, the research assistant had a personal interest in the issue. She asked to read some of the researcher's literature on the topic as well as giving feedback to

different ways of asking questions and suggested new themes to introduce. After a few interviews and meetings both the researcher and research assistant understood how to better work together.

A huge challenge to conducting the initial interviews with the 'lay' people was that people seemed unwilling to answer questions about their 'real' thoughts on the matter of FGC. One of the reasons for this is that both the research assistant and researcher needed to find out how to work together and to reach a common understanding of what a qualitative interview is. However, an equally important factor in understanding how to talk about FGC was for the research assistant to explain some of the Somali words and concepts of circumcision to the researcher. The method of discussing interviews with the research assistant allowed for the researcher to clarify concepts and ask follow up questions on the translation while it was being conducted and insightful data was gained. The research assistant was increasingly encouraged to ask her own follow-up questions throughout the interview if she felt it was natural.

### **Data analysis and writing up of the final report**

The last stage of the research project is the data analysis and writing up of the final report. As already stated this thesis views research, including the data collection, as a process and therefore analysis has been on-going and dynamic during and after the data collection period.

Upon returning from the fieldwork, all the material was read through to get an overview of the data. After this initial reading the data was coded into categories using the qualitative analysis software, Nvivo. Secondly the coded sections were printed out and re-read. Changes were made to some categories and sub-categories; some categories were merged, some added and some taken away (Bryman, 2004; Davidson & Tolich, 2003). Word searches on emerging topics and categories were conducted using Nvivo to further determine the content of each category. In total 58 categories were identified. These categories were further merged or sub-divided into 35 categories. Lastly, these 35 categories were divided into five main categories. Attention was given to avoid making assumptions about the data to allow for new topics to emerge.

It has also been considered important to reflect upon both the researcher and research assistants' pre-understandings and positionality and how this has constructed the data (Crotty, 2009; Fangen, 2004). In addition, the researcher has continuously reviewed the literature, and included new theoretical perspectives and empirical articles as a response to the themes that have emerged from the preliminary analysis.



## **Ethical considerations**

It is not entirely correct to look at ethical consideration as separate to the data collection as it is assumed that ethical considerations are integrated into the research process (Fangen, 2004). Nonetheless, it is important to emphasise a few ethical issues of note.

### *a. Formal ethical procedures in Norway and in Somaliland*

An ethical clearance was submitted to the Regional Ethical Committee in Norway in April 2011. The Regional Ethical Committee did not consider the research project as biomedical research and therefore stated that no ethical consideration was needed in Norway. However, the research project was then submitted for ethical clearance to Norwegian Social Science Data Services and the application was approved. The approval is a confirmation that the personal data stored and used in this research project has followed formal ethical procedures. As the research topic changed from reproductive health and IDPs to FGC, the Norwegian Social Science Data Services were updated during the data collection period and a continuation of the research was approved.

When in Somaliland, the Ministry of Health and Labour was contacted and permission to conduct the research was granted by the ethical committee in the Ministry. A condition of this approval was that the research project was affiliated with an agency in Somaliland. Affiliation was provided by the Dean of the Medical Faculty at the University of Hargeisa who approved of the project (see appendix 4 for details).

### *b. The sensitivity of the topic*

As it is a qualitative study with open-ended questions, the researcher is in little control of what information may be shared. FGC can bring up sensitive topics, such as family disputes and negative personal experiences of the practice. As a result ‘overdisclosure’ by participants may occur, where the interview is viewed as a therapeutic occasion (Smith, 1995).

The interview guide aimed towards representatives of organisations working on FGC focused on what their organisations were doing, and the opinion of the individual on the barriers and facilitators for eradication of FGC. The personal opinions shared beyond the official statements of their organisation are confidential and not associated with the organisation they were working for, and this was made clear to the research participants. The issue of ‘overdisclosure’ of sensitivity of FGC does not seem relevant to this category of research participants. However, after the recorder was turned off every participant was given an ‘information sheet’ about the research project and their participation in it with contact details of the researcher, research assistant and the supervisor of the research project (see appendix 5 for information sheet). In

addition they were asked if they had any questions for the researcher before and after the interview. All research participants seemed satisfied with their participation in the research based on the researcher's impressions.

The interviews with the individuals not working directly with FGC were looked upon as a different way of collecting data, and it was believed that an emphasis should be on the issue of 'overdisclosure' by the research participants in order to ensure whatever information was shared was done so voluntarily by the person being interviewed. It was emphasised before the interview that the researcher is a master student with no health background. It was also made clear that the notes and recordings would be destroyed upon completion of the project, and participants were encouraged to ask questions before the interview began. The participants were also encouraged to ask questions to the researcher or research assistant during and after the interview. After the formal end of the interview and when the recorder was turned off, an informal debrief between the research assistant, researcher and research participants occurred. This was intended as an opportunity to talk about any stress or concern about their participation in the research (Smith, 1995). Often the research participants asked questions of the researcher, continued to talk about topics or introduced new ones which were not discussed in the interview. The same written information sheet (which was translated to Somali) was given out and the phone number of the research assistant highlighted. As some research participants were illiterate, the research assistant also read the information sheet out loud to them at this point.

### *c. Informed consent*

As the nature of this research design is emergent and the interviews were qualitative, it was not clear from the beginning what data would be gathered and what the final research topic would be. Therefore it was necessary to treat consent as a process (Richards & Schwartz, 2002). An advantage of the research design in ensuring informed consent is that the design is flexible and the research is based on a negotiated process between researcher, research participants and/or research assistant.

All research participants were informed about the research project and their participation in it before they were asked if they were willing to participate. When the interview took place an introduction to the research project was repeated and research participants were again informed about their role in the data collection, topics that would be addressed, the publication of the findings (master thesis and academic journals), the use in the final report of the data collected (quotations and narratives) and that their anonymity would be secured as best as possible. At this point they were asked if they understood their role in the research, and if they consented to the

data being used in this way. If they then agreed to participate, they were asked to give their consent orally. There are two practical reasons for obtaining oral consent: (1) Several research participants were illiterate; and (2) a written consent was seen as limiting the extent to which interviewees are prepared to share knowledge. Initially, attempts at getting written consent from research participants were made. However, it was clear that a written consent form was not ideal in the research setting. Through further discussion with other researchers in Somaliland and the research assistant it was decided that oral consent and the written information sheet was appropriate in the research setting.

*d. Anonymity of research participants*

The nature of qualitative research is that it is descriptive and a large amount of personal details will be collected. This is an essential part of the analysis (Richards and Schwartz, 2002). However, throughout the data collection period, analysis and writing the final report, attention was paid to only identify the research participant to the extent necessary.

Each research participant was given a number in notes, and names of research participants were never recorded in the data analysis (transcriptions and notes) or the final report. Gender and age was identified as it will influence the research findings and analysis. For analysis and in the final report the research participants will be described according to their type of work, for example: 'Housewife', 'nurse'. The organisation that individuals represent will only be referred to in one of the following categories: 'multilateral', 'medical facility', 'government', 'INGO', 'NGO'. No further specification of any research participant's biological identity has been recorded. When possible and needed, identity specific information, such as specific behaviour or ways of dressing that can be easily detected by others in the close social circles was altered. It should be mentioned that some research participants specifically stated that their opinions should be public, not confidential.

*e. Data storage and handling*

Recordings and field notes were stored securely on the researcher's personal computer (which is password-protected) during the fieldwork. The research assistant only had access to the data collected throughout the data collection period, and not after the data analysis started. The research assistant signed a declaration that all information gained would remain confidential and would not be shared with anyone except the researcher (see appendix 4). During the write-up of the thesis the documents have been transferred to a computer that is protected by a password in an office in a research institute. All notes or details that may identify individuals are kept separate

to the data, using a key to connect it with the data. All field-notes and tape recordings will be destroyed at the time of completion of the master thesis.

### **Positionality and pre-understandings**

Positionality refers to “aspects of identity in terms of race, class, gender, caste, sexuality and other attributes that are markers of *relational* positions in society, rather than intrinsic qualities” (Chacko, 2004, p. 52, emphasis in original). Positionality does not necessarily mean how one sees oneself or what one thinks one stands for. Positionality is rather about the assumptions associated with the multiple identities a person carries at different times in different spaces (Chacko, 2004).

In the context of Somaliland, the perceived identities of me and the research assistant have influenced the data gained. In the same way my and the research assistant’s pre-understandings about FGC and of the research participants has influenced the data collected. It is therefore crucial to reflect upon and acknowledge positionality and pre-understandings in order to better understand cross-cultural complexities in conducting research and how to best go about it when collecting and analysing data. By being aware of the challenges and values of one owns positionality one may better negotiate “a complex spectrum of identities” in order to use a sensitive and appropriate research approach before, during and after the data collection period (Dawson, 2009, p. 1). Positionality, therefore, is not about ‘overcoming’ the disadvantages of its attributes, but rather acknowledging the influence of its attributes. It is insisted that assessment and adjustments throughout the research life cycle offer “well-grounded strategies for telling better stories” (Ramazanoglu & Holland, 2003, p. 169).

I am a 24-year old, Norwegian female with white skin colour. My male partner was with me during the data collection period. I travelled there independently, and I was not tied to any organisation. I covered my hair and wore skirts or Somali dresses during the entire fieldwork period. In approaching any community or individuals in Somaliland I believe I was perceived slightly differently than I at times desired and even realised. The following are two examples of how my presence influenced the data collection.

One person in particular made me aware that I could be perceived as a powerful fundraiser, and I will from now refer to him as ‘Ahmed’. Ahmed stated that:

...we are hoping that you mention us and make a very good fundraise. When you go back to your country you can easily meet those people who are donors. And you can give them detailed information about how we work, what we want, our functions and also our contact details, so you can connect us (Organisation 8)

Ahmed was a key gatekeeper to further research participants and I met him several times throughout the data collection period. Further, Ahmed called, emailed and showed up at some of my other interviews. He asked both the researcher and her partner for work, and after the researcher left the field Ahmed demanded that he be represented on the ‘acknowledgements page’ of the final thesis. These observations highlight several issues well worth considering in analysing the data. Firstly, it is worth considering if any of my other research participants have similar, but not so obvious perceptions about me, and how this ‘agenda’ of Ahmed’s and potentially others may influence the knowledge they shared. Secondly, I will have to ensure confidentiality for Ahmed in my thesis as well as making a point about how motivations for FGC-work can be understood. Thirdly, it is worth acknowledging that some of the research participants recruited through Ahmed were selectively recruited by him. Lastly, as I personally believe he might inhibit the eradication of FGC based on my observations, I need to keep in mind that I should be cautious in not letting my own understandings about the interaction with Ahmed dictate how I interpret the data gained from him and from others.

In one of the hospitals where I and my research assistant went, everyone except for one person refused to participate in the interview. The person who agreed to be interviewed did so on the condition that it was not recorded. She then told us that a few months ago a Western researcher or journalist had done similar research using a video recorder. She then published the recordings the following week on national television. Subsequently, the people that had participated in the interviews had encountered problem at work and with their families as their opinions were private and controversial to speak about publicly. This, of course, illustrates the importance of confidentiality and conducting ethical research. This incident may also explain some of the issues that I came across several times when interviewing ‘lay’ people – some did not want to talk too much about the pharaonic and why they still circumcised with the sunna circumcision. The way I was perceived based on my ‘Western’ attributes thus influenced what knowledge, and to what extent certain knowledge, was communicated.

In addition to these incidents it is worth considering the positionality and pre-understandings of the research assistant. As she grew up in the Middle-East she dressed slightly differently than most Somali women. Being a nurse she was also more educated than some of the research participants. Her perceived identity will have influenced how research participants decided to share their knowledge. Being opposed to FGC may have led the research assistant to ask and to translate the questions based on her understanding of how the world is, or should be. For example, the research assistant once translated how one of the housewives described pharaonic

circumcision. The research assistant made it seem that the housewife used very medical terms, like labia minora and majora, which I found hard to believe. When questioning the research assistant on this, it turned out that the housewife had not used these words, rather stating that something like 'the area down there' is cut. The active use of the research assistant's knowledge of the culture and interpretation of the data has been useful in shaping a more comprehensive understanding of the topic. However, the observations made by the research assistant are merely viewed independently and I recognise that they are just another knowledge claim. Nonetheless, I also view them as valuable because they enabled me to further explore knowledge shared, and observations made during the interviews.

It is hard to know how to overcome the challenges of positionality. Being a Westerner and 'outsider' in Somaliland society can be a disadvantage as you may be seen to symbolise a strong rejection of FGC. I believe I at times was perceived to be an imposer of Western cultural values and was seen as intolerant to Somali values in relation to FGC, thus limiting my ability to carry out the research. However, at other times this 'Western' attribute also worked in favour of the data collection. For example, it was possible to access a range of social groups, such as both men and women as I was less constrained by perceptions of traditional gender roles. Furthermore, it was obvious for most research participants that the researcher, and possibly also the research assistant, would make no judgements based on religion or culture. As a result of this, it was found that opinions could be shared that may not have been easily shared in general society or to a local person, due to social norms. After the interview was over one research participant expressed that she respected my views on FGC (I had explained that FGC was illegal in my country) while at the same time she respected that she was allowed for the first time to communicate her personal opinions on abandonment of FGC.

It is obvious that research participants changed their behaviour in meetings with me and the research assistant, and they may have different opinions about what they said when they see or read it afterwards. The data I have is data that was produced in the moments they were shared, and to some extent were 'true' at that time (Fangen, 2004). It is important to acknowledge that certain topics have been talked about in certain ways in different settings (for example interviews, informal conversations or interpretations by the research assistant) while I collected data. It is insisted that the researcher and research assistant's positionality and pre-understandings shape *all* the data collected. Thus it is crucial to acknowledge that the knowledge shared in this study is one way of describing the 'truth' about FGC, and the abandonment of it, not the only.

## **Limitations of the research design**

There are several limitations of the methodology presented. An obvious limitation is that a qualitative project cannot readily make generalisations (Ramazanoglu & Holland, 2003). It cannot measure prevalence of FGC to determine the 'truth' about the status quo of the phenomenon, and it may not make solid generalisations. However, that is not commonly the aim of qualitative research methodologies.

There were several practical aspects that limited the scope of the research such as the researcher being a woman, finances and time-frame. Due to the political situation in the broader Somalia, for example, the researcher's safety being in the country, both as a woman and as a Western person was thoroughly considered. It is known that 'extremist' and pirate activity is growing in the country and deadly attacks targeting foreigners have been known to occur, even in Hargeisa (Bisset et al., 2010). The researcher decided to stay in Hargeisa only, as she was not tied to an organisation in Somaliland. Moving outside of Hargeisa would require a police escort and lacking the support of an agency *if* something were to happen to the researcher it was considered that Hargeisa was the best place to stay. This issue naturally influenced access to research participants. Due to this the research lack insights into the rural area and it is assumed that the data may be quite different to what was collected in Hargeisa.

Another important limitation to consider is that due to time and financial constraints the translation has been done by the research assistant only. She was constantly reminded to try to separate her own understandings from the translation itself and to translate interviews verbatim. The design of the translation allowed plenty of time to listen to the interview after it was conducted and the content is believed to accurately reflect the research participants' opinions and words. Listening to the tape recordings, however, sometimes triggered discussions based on differences in the way the content was interpreted. Some of the findings presented are therefore a result of a negotiated understanding of what was expressed, with the researcher and the research assistant exploring and challenging each other's understanding. Nevertheless, without using a research assistant, the data would not have been obtained.

## **Strengths of the research design**

The main assumption of this research is that FGC, and its eradication, depend on social constructs that are constantly challenged and negotiated. A social constructionist epistemology offers an insight into power relations, control and society that are valuable to FGC research. Through a qualitative methodology the research allows for asking in-depth and sensitive

questions as well as for interpreting what is seen, making use of observations, informal conversations and relevant literature.

The flexibility of the research design is also valuable given the potential challenges involved in conducting research in an 'unstable' area. Before entering the field it was highly uncertain how the researcher could get plane tickets, accommodation and how long she could stay in the field. At certain times, such as during times of political turmoil and following natural disasters, access to the field could have been limited to humanitarian workers and strict security clearance may be needed (UNHCR, 2011). The research was tailored through an explorative and flexible design to fit this challenge without impeding the overall aim of the research.

An obvious strength of this research approach is the fact that as very little research has been done in the area, predicting what would come up during the data collection is hardly possible. As discussed in the literature review, the area of FGC, eradication and Somaliland is very little researched. Due to this, one cannot know in advance what the most important research questions are and having a relatively open approach will let the researcher avoid as many prejudgements as possible before entering the field. A rigid design before entering the field would have counteracted this aim. By proposing a flexible approach, the whole research cycle was questioned, enabling changes and improvements to be made throughout the actual research period. Continuous evaluation of the research design itself resulted in a tailor-made research project that reflects the multiple issues concerning FGC, and abandonment of it, in Somaliland (Davidson & Tolich, 2003). This flexibility also allowed for consideration of how different worldviews and cultures may impact upon what are defined as 'FGC', 'eradication' or 'abandonment'.



## **Chapter 5: Perceptions of female genital cutting and of abandonment in Hargeisa: A presentation of the findings**

This chapter provides a comprehensive overview of the data collected during the fieldwork period. This includes data from qualitative interviews; informal conversations; the FGM/C-workshop; the UNICEF-workshop; interpretations made by the research assistant; observations and field-notes taken by the researcher; reports and evaluations obtained during the fieldwork; and FGC material collected in the public sphere.

The data are presented according to three categories which together encapsulate how FGC and FGC abandonment are understood in contemporary Hargeisa. These are:

- Descriptions and explanations of FGC
- FGC initiatives and activities
- Ideas, opinions and understandings about eradication and abandonment of FGC

Each of these categories is further divided according to various themes that were identified during data analysis.

The data show that what constitutes FGC is negotiated at different times, in different ways and in a diversity of social settings. Ideas about abandonment of FGC exist in a multiplicity of societal structures that bring FGC into being. Thus it is crucial to consider cultural and social beliefs related to practices of FGC and to get an overview of current FGC-work in order to comprehend how strategies to eradicate FGC can work in current day Hargeisa.

### **Descriptions and explanations of FGC**

This category summarises research participants' descriptions and explanations of FGC. FGC and the many different aspects of it are often described in contradictory ways. While there appears to be a relatively consistent understanding of the way FGC has been practiced in the past, most participants indicated that contemporary FGC practices were qualitatively different to these. However, how this change is understood and presented was not always consistent among research participants.

*a. Defining FGC in Somaliland: 'Sunna' and 'pharaonic'*

Research participants commonly made a qualitative distinction between two types of FGC: 'Sunna' and 'pharaonic'. Pharaonic circumcision was generally seen as the most severe form and was strongly associated with the past. Sunna circumcision, on the other hand, was seen as a more recent and milder practice.

It was found that pharaonic circumcision can be compared to the WHO definition of type 3 FGM where the vaginal opening is narrowed by creating a covering seal. The inner and outer labia are cut and repositioned to form the seal. The clitoris may or may not be removed. Pharaonic circumcision is often referred to as infibulation (WHO, 1997). One of the housewives interviewed described what the procedure of pharaonic circumcision involves:

In the old days girls would face a lot of problems with circumcision, with the pharaonic type. They used to use sticks and woods to stitch it, and later on they used to tie her and make her unmovable for seven days. After that when she needs to urinate it is really hard and it causes a lot of pain, but they have to handle it. (Housewife 9)

From this description it is clear that pharaonic circumcision is an operation resulting in severe pain, where recovery takes at least a week. This pain was, nonetheless, described as a necessary pain that the girl had to endure in order to satisfy established cultural rites.

Furthermore, pharaonic circumcision is strongly associated with on-going health problems. For example, one research participant, a nurse, was asked what she considered to be the problems of pharaonic circumcision. She explained:

[...] she may get a lot of problems such as dysmenorrhea, difficulty of urination [...] and difficulty in deliveries [...]. Sometimes, if she delivers in her home, she may get fistula. So there are a lot of problems. (Nurse 4)

It became clear that research participants considered pharaonic circumcision to be a traditional form of FGC that was now being superseded by milder practices. As one of the housewives expressed:

Thanks to God that we get removed from that type [pharaonic] and now we get into this new type [sunna] which is better for her. (Housewife 9)

However, pharaonic circumcision was nevertheless still considered common. When asked about which type of circumcision she most commonly saw, a nurse claimed that pharaonic circumcision was still the most common, "because sunna is new" (Nurse 4).

According to one research participant who has researched FGC for many years, sunna circumcision can be a very minor procedure involving nothing more than a small incision of the clitoris.

A very small part of the clitoris should be cut. Just make the place bleed and that's ok, no stitching, nothing. (Organisation 15)

However, a number of research participants also pointed out that there is no common understanding or definition of sunna circumcision. This means that in practice it can be as severe as the pharaonic type, as illustrated by the same research participant:

In the end there is no practitioner or doctor that will teach you to perform this practice [sunna] [...], and they are not trained. So even some of them will do the infibulation and they will tell the mother who doesn't know anything that it is sunna, you know. (Organisation 15)

The view that sunna circumcision is not clearly defined, and as such can range from a small prick of the clitoris to something as severe as pharaonic circumcision, was confirmed in the FGM/C-workshop and in many of the interviews with both representatives of organisations and lay people. Therefore, although a distinction is consistently made between 'pharaonic' and 'sunna' practices, the two are not necessarily mutually exclusive.

In addition to the terms 'sunna' and 'pharaonic', the Somali word 'buurya qab', which means uncircumcised girl, also came up in a number of interviews. This word was explained by the research assistant as a negatively laden word and some of the research participants claimed that it is "a big challenge" and "not good" to be a 'buurya qab' (TBA 6; Nurse/midwife 7).

#### *b. Translating circumcision*

The distinction between pharaonic and sunna circumcision was not always captured using the definitions and categorisations commonly used in English language descriptions. In the beginning of the data collection the researcher used the terms 'FGM' and 'circumcision' when asking questions, believing that this referred to all types of circumcision. However, it subsequently became apparent that research participants, particularly the lay people, often did not consider sunna to be contained in either of the terms 'FGM' or 'gudniinka' ('gudniinka' is a Somali word sometimes used by the research assistant to translate the English term 'circumcision').

The abbreviation FGM, rather than female genital mutilation, is commonly used by staff of organisations working with issues related to female circumcision and has entered the Somali lexicon, particularly among interviewees who worked within the health sector. However, it was

found that not all of the Somali research participants used FGM to describe both sunna and pharaonic circumcision. In interviews with lay people it seemed that most understood FGM to mean pharaonic circumcision only, and that sunna was something else entirely. Based on this finding, it became unclear whether the representatives of organisations used FGM to only refer to pharaonic circumcision, or to all kind of cutting of female genitalia for non-medical reasons.

The disjuncture between FGM as it is understood in English and Somali is usefully demonstrated by the picture 1 to the right. It shows a t-shirt used in FGC eradication campaigns by a local NGO. In English the t-shirt reads ‘eradicate FGM from Somaliland’. However, the Somali text can be translated as ‘eradicate *pharaonic* circumcision from Somaliland’ – a subtle, but potentially crucial difference.

Picture 1: Campaign slogan from a local NGO in English and Somali



Similarly, the translation of the word circumcision to ‘gudniinka’ was equally problematic. For example, in the first interviews with lay people and representatives of organisations, participants were asked if he or she were to have a daughter whether they would circumcise her. Everyone answered no. However, when exploring the ways people understood the different concepts it soon became apparent that sunna was not always understood as circumcision. Rather, most of the research participants considered sunna to be an acceptable practice, not correlating with circumcision. Consequently most of the research participants saw no contradiction in stating that they would indeed let their daughter undergo this procedure (i.e. sunna circumcision) at the same time as they argued that they would not allow their daughter to be circumcised.

The fact that sunna circumcision is not necessarily seen as circumcision can be clearly seen in an interview with a male research participant. He argued that he was strongly against circumcision (‘gudniinka’). However, when questioned further he expressed support for the continuation of sunna. Thus clearly not seeing sunna as a practice encompassed by the term ‘gudniinka’:

I want to stop all the circumcision [‘gudniinka’] [...]. We should continue the sunna [...]. It [gudniinka] is not something in our religion [...]. Sunna is not something that has a problem. It causes no problems, no harm and it’s not a big surgery. Just a small surgery and after it they’re all ok. (Male 16)

While there are obvious differences in interpretations of FGC practices between English and Somali, there are also different interpretations amongst Somalis. This is exemplified by a man who had not heard about sunna circumcision. He believed that girls either went through pharaonic circumcision or were uncircumcised:

Man: There is the pharaonic when the whole area is closed and there is a small opening for the urine to come out from it.

Research assistant: Do you know any other types?

Man: No.

Research assistant: If she is not pharaonic can she be some other type?

Man: No.

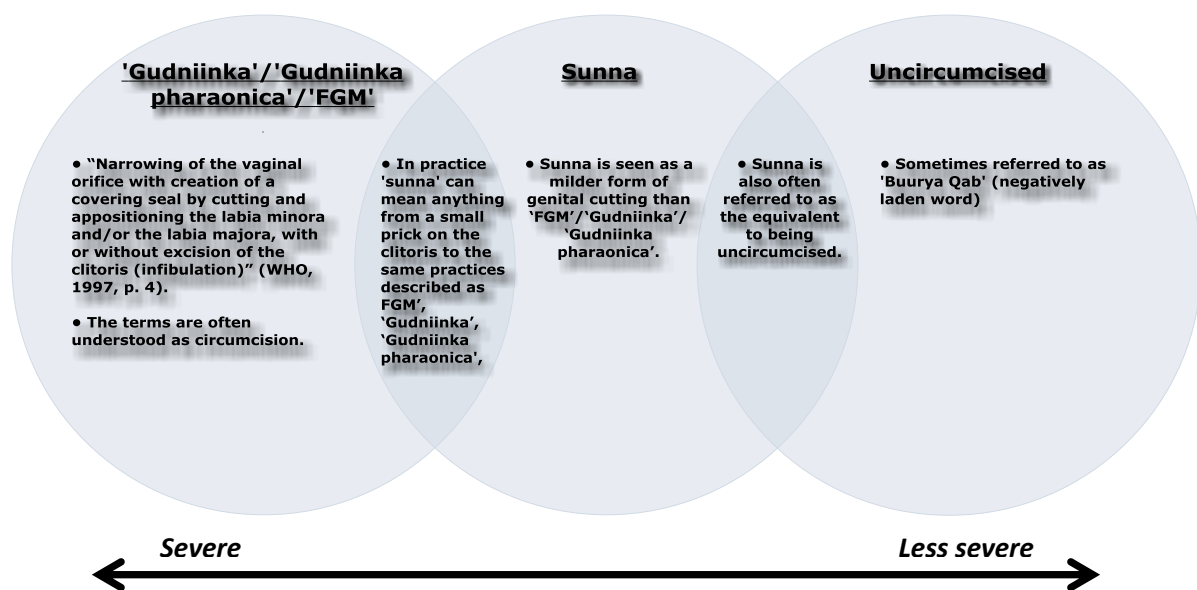
Research assistant: Do they leave her like that without any circumcision?

Man: Yes. (Male 14)

As a result of these differences in understandings of key terms, it was necessary to pay careful attention to the ways in which participants conceptualised FGC. In most interviews with lay people one can see that most of the discussion about eradication of FGC only refers to pharaonic circumcision which correlates to the term 'FGM' or 'gudniinka' in Somali. It is therefore fair to assume that when the term FGM is used in Somali it mostly refers to pharaonic circumcision, whereas in English it refers to all types of FGC. Combinations of the word 'sunna' with 'gudniinka' were not used. Therefore sunna can be a practice that exists outside of gudniinka and FGM, representing another category altogether.

The understandings of FGC presented by research participants can therefore be conceptualised schematically as shown in figure 7 on the following page.

Figure 7: Conceptualising Female Genital Cutting in Hargeisa



The figure illustrates that there is not a complete conceptual separation between pharaonic and sunna practices, nor is there necessarily a complete separation between sunna and the view that a female is uncircumcised. However, based on the data, a female that has had sunna circumcision cannot be termed 'buurya qab'.

*c. Sunna as a new and 'better' type*

It is clear that all interviewees believe there is a strong trend towards abandonment of pharaonic circumcision. This abandonment is illuminated in the perception that pharaonic circumcision is a medically harmful traditional practice which is not consistent with what some research participants referred to as a "modern" society (Midwife 2; TBA 5; Beautician 13). Neither was it seen to be consistent with contemporary religious ideas. As such, sunna was frequently described by lay people as a new, modern and better alternative to pharaonic circumcision.

The findings show that most people perceive sunna circumcision as having no medical complications for the girl. One of the TBAs interviewed, who has long experience in circumcising girls, explains:

[N]owadays they just do this small incision without any problems. And they leave her and later, on the delivery time, she would have no problems. Since there are not any other parts that get removed from the beginning, the delivery will be really easy for her. (TBA 6)

The other TBA claimed that girls are so unaffected by sunna circumcision that they are able to move about and play immediately after the procedure:

... when we finish doing this circumcision [sunna] for the girl she went home and went playing, but in past times the girls that they were doing the pharaonic circumcision would have to keep lying flat on the bed for around maybe twenty days. (TBA 5)

However as highlighted above, although there is a new term (sunna) being used, practices of circumcision can remain the same, as the term holds no standard meaning. This is illustrated by a representative of an organisation who works with FGC-counselling in a medical facility in Hargeisa:

Most of them [the patients in the medical facility] they stop the severe type of circumcision. They do the sunna, but the sunna is just all the same [as pharaonic]. Although it is same, they say they do sunna type because they know the problem of the infibulation. (Organisation 6)

She implies that because people know the problems of pharaonic circumcision, it seems that supporting it is almost taboo. By using the term sunna it is less likely that one will be judged for undertaking a harmful practice, it is rather socially accepted.

While harmful medical consequences may therefore remain, the social implications of replacing pharaonic circumcision with milder forms of circumcision are also uncertain. A number of research participants suggested that girls who had undergone sunna circumcision may face social exclusion and difficulties in marriage. For example, a man from a multilateral organisation claimed that:

... there is this, this pressure from the youngsters. That someone who is circumcised is ok. Someone who is not circumcised is not ok in their views. (Organisation 9)

Similarly, one of the beauticians interviewed pointed out that:

[Some people] think that this girl who got the sunna is not a good girl, and she might have had sex before getting married [...]. So she's not, she's not a good girl for them so if she's closed and got stitches she's a good girl for them, yeah. (Beautician 12)

Therefore although sunna circumcision is presented as a new and improved procedure there is still grounds for concern for those undergoing the procedure. It thus seems natural to explore some of the reasons for circumcising.

*d. A changing, but still meaningful practice*

The reasons for circumcising are complex and multifaceted. In Somaliland, it seems that it is the social norm to be circumcised and if one is not circumcised one is not really considered a complete female. Currently there seems to be different interpretations over why one should circumcise. However, many of the research participants, both lay people and organisation workers, referred to tradition, the nature of rural and nomadic lifestyles or the need to suppress female sexuality when explaining why one needs to circumcise. Religious ideas were also strongly used to justify the practice.

One research participant who worked for a local NGO explained that one of the origins of pharaonic circumcision lay in the desire to protect girls against sexual assault. She argued that rural and nomadic lifestyles, where girls walked far distances to fetch water and firewood or to tend animals, made them vulnerable to sexual assault, and pharaonic circumcision therefore can be seen as a means to protect girls. Along with some other research participants she claimed that it had been reported on the radio, on the TV and in the newspapers that rapes were increasing as a result of girls no longer undergoing the pharaonic circumcision. The same research participant further explained that she had heard that rapists try to find girls that have sunna circumcision and rape them. As a result she expressed concern that protection of girls could be used as an argument against sunna circumcision and against eradicating pharaonic circumcision.

Throughout most interviews circumcision was seen as important in order to become a woman who is ready for marriage and to have children. One of the TBAs referred to a traditional poem which described pharaonic circumcision as a ritual consisting of three stages, or rites of passage, that a female has to go through in her life. The poem expresses that a female will not be happy in her life without going through these stages. The first stage is the time of circumcision when the girl becomes a woman. The second stage is at the time of marriage when the girl is cut in order to be ready for sexual intercourse. And the last is at the time of infibulation when she is cut completely open in order to give birth. While the explanations provided by the poem show some of the cultural beliefs underlying practices of circumcision, it is important to note that these can only be demonstrated through what is supposedly pharaonic, not sunna, circumcision.

A number of research participants also linked FGC explicitly to the suppression of female sexuality. One of the housewives, for example, referred to the clitoris as 'haram', which means something that is forbidden in Islam, and argued that it therefore should to be removed. Similarly, when asked about the future of the girls who undergo sunna circumcision, as opposed to those undergoing pharaonic circumcision, one of the housewives expressed concern that sunna



circumcision would allow females to get aroused; something she considered to be problematic. She claimed that girls who undergo sunna circumcision would need to marry young:

These girls who have sunna type got all their feelings. They are going to feel more aroused as they get older, they are going to have sex with anyone they meet, and so they will get pregnant and that would cause a problem for them. But all the old girls who have circumcision, the circumcision make them feel nothing so it was ok with them [...]. But these girls [with sunna circumcision] would do whatever they want. (Housewife 9)

Changing meanings of the practice can be seen in the descriptions provided by different generations. The younger generation (usually described as younger than 25 years old) were often referred to as the new generation as exemplified by this man, who was about 23 years old himself:

There is a new generation, a new century that comes and people needs to adapt to this new generation and century. (Man 14)

Most research participants stated that the young mothers nowadays will only perform sunna circumcision on their daughters. One of the housewives explained that her two oldest daughters had undergone the pharaonic circumcision, while the three younger ones had undergone sunna circumcision. Her reasoning for this was that because of the FGC awareness-raising campaigns she had learnt that pharaonic circumcision was harmful and not a religious obligation. She therefore decided that she would not let her younger daughters go through what she herself had. Some of the organisation workers interviewed insisted that some even decide not to circumcise their girls at all.

However, all of the lay people interviewed, except the religious scholar, insisted that sunna was still a necessary practice. Many of these explained that it was a religious obligation to undergo sunna circumcision, while others explained that it was a cultural obligation or habit. This is illustrated by a beautician who argued that pharaonic circumcision had no advantages and should be eradicated, while the sunna was still necessary to preserve for cultural reasons:

[Pharaonic has] no advantages. But sunna is needed as it is a Somali traditional habit to circumcise the girl. (Beautician 11)

Differences in FGC practices between rural and urban areas were emphasised by both lay people and organisation workers, either when asked about it or if they themselves brought it up throughout the interview. It is important to note that this interpretation is based on individuals living in the city, in Hargeisa. When asked about the differences between the rural and urban areas it was commonly agreed that in the rural areas there is less awareness of FGC issues and

therefore people believe it is a religious obligation to do the pharaonic circumcision. One of the beauticians explained that those living in the rural area had still not heard about the new type, and needed help to abandon the pharaonic circumcision:

The people in the rural area are still the same, and it's still common to do the circumcision [i.e. pharaonic]. [...] we need to increase the eradication campaigns [...] so they can know the problems that it causes, the health problem that it cause. (Beautician 13)

At the UNICEF-workshop several participants claimed that the rural areas are neglected in general and some of the organisation workers and lay people interviewed claimed that more research and FGC awareness initiatives are needed in the remote and rural areas.

Although not fully recognised as circumcision, sunna is by many still seen as a necessity that reflects what it means to be a female in Hargeisa. It seems that the reasons for pharaonic circumcision do not necessarily apply to sunna circumcision. However, there are certain elements where the reasons for circumcising are the same; in particular for the girl to become a woman and be ready for marriage, and that it is a religious obligation. The current meaning of FGC in Hargeisa consists of a diversity of interpretations and is not clear-cut. Nonetheless, it appears that new meanings of circumcision are emerging.

#### *e. Decision-making*

Decision-making emerged as an important theme when describing FGC. Based on the interviews it seems that the most common age for circumcision is somewhere between six to twelve years old. However, some reported having heard of girls being circumcised as young as three years old and as old as 18 years old. Although one research participant recounted having heard of girls that have moved to Somaliland from the diaspora and subsequently chosen to get circumcised, the decision to circumcise is almost never one that the girl makes herself.

Most people claimed that it was the mother's role to decide if, when and how circumcision would happen. If the mother refused or was unable to take the decision, the grandmother or another close female relative (e.g. aunt, sister-in law) would step in. The father apparently has very little influence when it comes to the decision to circumcise according to one of the beauticians:

90 per cent depends on the mother, but 10 per cent sometimes depends on the father. In our culture men are supposed to just take care of things outside, and the mother is the one who is directly responsible for the kids, and that is why she takes the responsibility of that decision [to circumcise the girl]. (Beautician 12)

Similarly, a representative of an organisation working at a medical facility explained that even though her father was opposed to the practice, her mother made the decision for her to undergo pharaonic circumcision:

When my dad came back that evening and found that I had been subjected to it [pharaonic circumcision] there was a big fight, well a big argument, between my parents which I could hear. And this made me understand that whatever had been done to me was not with the approval of my father. (Organisation 10)

Several of the lay people also talked about the tradition of ensuring that a girl is circumcised when the time comes to marry. Some stated that the families of the two spouses discuss circumcision before permission to marry is granted, while others claimed that it is only the couples that talk about circumcision before marriage. A number of research participants, among both lay people and organisation workers, recounted stories of newly-wed husbands who immediately divorced their wives after finding out that they were not circumcised or had the sunna circumcision. In these instances it was considered to be a great shame on the girls' mothers and they were blamed for not looking after their daughters' futures. One of the TBAs explained how as a mother it was her responsibility for taking care of her daughter's future and for ensuring that she was socially accepted:

TBA: I got five daughters, and two of them got pharaonic type and the other three I done the sunna type for them

[...]

Research assistant: If you didn't circumcise your daughter with sunna, would that be a problem?

TBA: Yes, because it's [uncircumcised] not in our culture and I would have not done this to my daughter, make her separated from other people. (TBA 6)

However, it was apparent from statements made by some of the younger research participants that even though primary responsibility for circumcision lay with the mother, the father could also have a say. A male research participant who worked for a multilateral organisation, for example, indicated that it was him who had made the decision not to circumcise his daughter. After his daughter was made to feel abnormal at school, it was also left to him to explain to his daughter why she was not circumcised:

[T]here is also the peer-pressure, when she comes home one day and asks her mother: ‘Why I’m not circumcised, mother, because other girls are telling me?’. ‘It’s to do with your father, when your father comes ask that question’ [replied the mother]. (Organisation 9)

Similarly another man in his early twenties claimed that he could influence the decision:

If I get married and if I have a daughter, I’ll tell my wife not to do a circumcision for my daughter. (Male 14)

The extent of potential male influence can also be illustrated by an expatriate doctor and a nurse who explained that a signature from a husband, father or male relative is always needed before general medical treatment can be given to a female patient. Similarly, the religious scholar that was interviewed explained that if there is disagreement over decision-making between a husband and wife, the wife should listen to her husband:

Actually in the female issues the mother solves most of it. But in the decision making I think she, if the two persons respect each another, she would listen to him. (Religious scholar 15)

Although the female apparently is concerned with ‘female issues’, it seems that larger family and social structures play in when it comes to decision-making. Therefore decision-making around FGC is not as straight forward as is often claimed. Rather, it seems that the decision to circumcise is dependent on most social actors in a girl’s family network – except for the girl herself.

#### *f. Questioning FGC prevalence*

Arguably, no one knows the prevalence rates of FGC in Somaliland. Although most sources cite a prevalence rate of above 90 per cent, many of these figures can be questioned (Ismail, 2009). Some of the medical facilities in Hargeisa have charts to fill out in order to keep track of FGC prevalence rates. Through an informal conversation with a doctor at one of these facilities the researcher learnt that these charts were often filled out by unskilled staff after the patient had left.

Furthermore, even if charts are filled in correctly, it is not always easy to accurately assess which, if any, type of circumcision a woman has undergone. An expatriate gynaecologist explained that it was difficult to determine the severity of the circumcision of some of her patients. She thought that this could be due to the tissue growing as the girl gets older, and in this way it is hard to determine what operation she has gone through earlier in life. As the operation of sunna circumcision is less severe than pharaonic, this may imply that practices of sunna circumcision

actually exist and are harder to identify. Nonetheless, there seems to be several challenges in accurately tracking the phenomenon.

Noticeably, one research participant representing an international NGO questioned the severity of the phenomenon:

[T]here are different degrees of the FGM but what you see here it's not the extreme case that you see in Sudan or even in Somalia, in South Central. (Organisation 7)

The participant continued by claiming that there were not enough patients with FGC-related complications to justify an INGO doing an intervention on it:

Some of the NGOs they left because, well, it's not enough volume of patients to justify an action, I mean [INGO] was recently here in Hargeisa and they wanted to do a fistula ward in Hargeisa hospital and provide treatment for fistula on a regular basis. However, there were not patients enough to justify regular interventions. (Organisation 7)

This insistence of a lack of FGC complications needs to be seen in light of the aims of particular organisations. In this case, for instance, emergency assistance may not focus on eradicating FGC as it is not considered an emergency need. Additionally, yet again it may indicate that sunna circumcision is practiced, and that complications related to sunna are less severe.

Nonetheless, because of such comments and the fact that there is little data on prevalence of FGC and health complications related to FGC in Somaliland, it is worth questioning the motivations for doing FGC-work. One of the research participants, who is a TBA and works as a circumciser, stated that:

If you hear about [FGC] campaigns that mean a lot of funds, a lot of money, to do the campaigns. It is not necessary to have these campaigns [...]. We just need that money, but not the campaign by itself. (TBA 5)

She made it obvious that the often Western-driven initiatives provide much needed money, but that FGC is something that can easily be eradicated by the people of Somaliland themselves.

Through several informal conversations and in interviews with representatives of organisations working in Somaliland, it was found that there is often significant competition for funding and that the impetus for doing FGC-work, or any aid work, depends on the preferences of international donors. One respondent representing a multilateral organisation confirmed this view:

Researcher: So with local organisations that are working with FGM, do you think they are doing it for, I mean, are they doing it because donors want to spend money on FGM or are they doing it because they think there is a problem?

R: Both. There are some people who really believe that's a problem and those who are doing it for funds. (Organisation 9)

The implication of this is that actors may perceive there to be a financial benefit in presenting FGC as a more significant problem than it actually is. It may also imply that there is an acute need to measure prevalence rates of the phenomenon.

### **FGC initiatives and activities**

As there is very little published literature on Somaliland in general, and FGC in particular, the data collection aimed to get an overview of FGC initiatives and activities undertaken in Hargeisa, and to some extent Somaliland. In order to gain a better understanding on how FGC eradication is perceived, mapping initiatives designed to eradicate FGC was considered crucial. When mapping FGC-work in Somaliland it became apparent that there are several different forms of intervention.

In addition to clearly defined work, as represented by the organisations that are intentionally working to eradicate FGC, there exists more loosely-defined, informal work related to FGC eradication. This informal work refers to different social actors in civil society such as family members and friends. Informal work also refers to activities undertaken by these actors such as talking and discussing FGC between friends, family members and colleagues. The history of FGC eradication campaigns and the influences of war and Somaliland's claim of independence are also important to consider when mapping initiatives designed to eradicate FGC.

#### *a. Locating eradication of FGC historically*

Based on one of the research participants who now works for a multilateral organisation, the history of eradication of FGC in Somaliland extends to the 1970s before Somaliland had claimed its independence from Somalia. As the research participant explains, the government in the capital city of Somalia, Mogadishu, initiated the FGC-work:

You know, in Somalia when you go back during the Siad Barre-period. He put a system to stop FGM altogether. Because there was a government, and they put a system and anyone who does not follow that road, then there is a punishment. And that works a while. But that government is not anymore, eh? (Organisation 9)

One of the research participants, who had been involved in initiating the work to stop FGC in Somalia in the 1970s, explained that this work had been interrupted by war in Somalia and the war between Somalia and Somaliland in the 1980s:

That's how far we went [in addressing FGC] and then of course in 82, 83 the war started between Somaliland and Somalia. There was a Civil War that separated Somaliland from Somalia. Somalia is still in a mess, Somaliland is busy rebuilding itself. (Organisation 10)

This research participant later continued the work to eradicate FGC in Somaliland and was one of the key drivers in the continuation of efforts to eradicate FGC in the late 1990s. This was also the time when the international community started to seriously engage in the issue. FGC initiatives continued through the 1990s and 2000s, with the work being done by NGOs, INGOs, multilateral organisations and the Somaliland government. However, several research participants explained that FGC was not really seen as a priority in the 1990s as there were many more pressing emergency needs. As one research participant explained:

I remember the time when we came here, there were not even roofs. So it was quite difficult at that time to start to talk about FGM for the people when they needed emergency help. Even now it is so that when the drought is very bad the people are focusing somewhere else, not on FGM. (Organisation 5)

It thus seems that FGC eradication must be seen in the broader context of political, social and economic development in Somaliland.

Nevertheless, the 1990s was a crucial period in efforts designed to eradicate FGC. According to one of the TBAs it was after the war and the independence of Somaliland that sunna circumcision began to be popularised. She explains that it was at this time that she learnt how to perform sunna circumcision and was among a new generation of circumcisers:

I started working as a TBA in 94. When I started working as a TBA that's the time that sunna type started. I am of the people that started with the sunna type. (TBA 5)

It seems, therefore, that the self-declared independence of Somaliland in 1991 marked the beginning of a new era both for Somaliland and for how FGC could be understood.

In recent years it seems that FGC has garnered increasing attention. This is evidenced by the number of different actors working on FGC-related issues in Somaliland as well as current governmental efforts to draft a common statement on the issue - a process involving a FGM/C-workshop which the researcher attended in November 2011. The local organisation 'Nafis' is the

main network of FGC initiatives and was established in 2006 (Nafis, 2006). In June 2011 the first workshop on collaboration and coordination of eradicating FGC in Somaliland took place. Several organisations working on FGC issues met for the first time to reach a common approach towards eradication the phenomenon (Musse, 2011).

*b. Philosophies of eradication*

Different activities aimed at eradicating FGC are underpinned by different eradication philosophies which serve to frame FGC in a particular way. This research has identified three main ways in which organisations frame FGC eradication in Somaliland. These are:

- FGC as a social/cultural issue.
- FGC as a human rights issue.
- FGC as a medical issue.

These three approaches are not easily identified in Hargeisa, and should be viewed as interlinked together creating a fairly holistic approach to eradicating FGC. In addition to these three overall approaches, organisations working on FGC must also position themselves according to philosophical ideas of harm minimisation versus total eradication.

Organisations approaching FGC primarily as a social/cultural issue attempt to engage constructively with traditional local structures to negotiate new meanings and understandings of FGC practices. Organisations adopting this approach tend to emphasise the importance of dialogue with traditional/religious/community leaders and try to stimulate endogenous change.

Somaliland currently has no laws banning FGC. However, it does have a national gender policy that is currently being implemented by the Ministry of Labour and Social Affairs. FGC forms a part of this policy, under the subheading 'harmful traditional practices', that frames FGC as gender-based violence (Ministry of Family Affairs and Social Development, 2008; Ministry of Labour and Social Affairs, 2011). However, one of the government representatives explained that the Western idea of gender-based violence does not correspond to local understandings of FGC in Somaliland:

We had to subtract the FGM [from a pure gender-based violence view] for the reasons that the communities are feeling a little bit relaxed [...], they don't see it as an outsider's business to engage. So we said ok, we are going to keep it that way that is working here. But from the Ministry point of view we combine all the information under gender-based violence.  
(Organisation 14)



In this view, it seems that a communities favour local-driven initiatives, while discarding foreign interference in approaching FGC.

UNICEF, together with governmental organisations, INGOs and NGOs, is currently in the process of implementing a child protection system in Somaliland. According to arguments presented at the UNICEF-workshop, protection of these rights needs to be achieved through social structures, ranging from formal governmental structures to informal community structures. A child protection system would, according to views expressed at the workshop, provide a sustainable national approach. UNICEF is thus explicitly basing their activities on a philosophy which frames FGC as an issue of children's rights. According to this philosophical approach FGC is an integrated part of a holistic approach to protect children against breaches of human rights (UNICEF, 2011).

Finally, organisations that view FGC as a medical issue approach it in terms of its effects on the health of women and children. While this approach has been crucial in changing practices of FGC, it also means limiting criticism to those aspects of FGC that are proven to have negative health consequences. For this reason an organisation worker claimed that it was useful to use pharaonic circumcision as a scapegoat for health problems as it intrinsically is linked:

We are not too shy to blame FGM. You know, it may or may not be true that she has a fistula because she has an FGM. But it is certainly one of the factors that has delayed the baby coming out. (Organisation 10)

Cutting across these three main philosophical strands is a debate over harm minimisation versus total eradication. This manifests itself in Somaliland in a debate over whether organisations should promote sunna circumcision as a safer alternative to pharaonic circumcision or whether they should oppose all forms of the practice. One research participant explained that her philosophy about the best approach had changed from a focus on total eradication to one of harm minimisation and gradual abandonment:

Thirty years ago, or thirty-five years ago my philosophy was yes do it or not, [...] just two options. But with all the years that have gone and the problem is still there because we discovered that 97 per cent of the women who come to our clinic have been circumcised, and 98 or 99 per cent of them have had the most severe form [pharaonic] [...]. So thirty five years after we start the campaign, and I have come to this stage now that I say 'half a loaf is better than no bread at all'. [...] And my strategy is if you are going to do it at least you should do the milder form. (Organisation 10)

This research participant reasons that because no progress in eradication has been made, it seems obvious that a focus on total eradication is not working. However, through a focus firstly on harm minimisation through adopting the sunna type, a process of abandonment may eventually occur.

*c. Stakeholders in eradication of FGC*

There are several different organisations working to eradicate or reduce FGC in Somaliland. These include governmental organisations, local NGOs, international NGOs, bilateral organisations, multilateral organisations and medical facilities (Musse, 2011). In addition to this civil society is a main agency for change. Several of the lay people emphasised that they do their own awareness-raising by talking to family, friends and neighbours and by challenging the traditional decision-makers (mothers, grandmothers and female relatives). A man in his early 20s explains how he wants to influence his future wife:

I will tell her [potential wife] not to do a circumcision for our daughter and tell her the problems that it will cause and how that would affect her school and her life [...]. So this is a sort of awareness that I make my wife aware, and she can do that to her friends and other people that she knows. (Male 14)

It is obvious that husbands and fathers can play a role in eradicating FGC. Nonetheless, several more stakeholders were identified by all research participants. People such as health workers, circumcisers, community leaders and religious leaders/scholars were identified by both lay people and organisation workers as people who have powerful and respected positions in Somaliland society, and in that way are influential in initiatives designed to eradicate FGC. In addition, teachers that are targeting FGC education in school were looked upon favourably by some of the organisation workers, and they were emphasised at the FGM/C-workshop as potentially new stakeholders in initiatives designed to eradicate FGC. One of the beauticians suggested that journalists could write about FGC and the health complications in sections of newspapers that are targeted at women. The researcher herself also possibly contributed to awareness-raising as she encouraged people to express their thoughts on the matter. Lastly, there seems to be consensus by all research participants that the young generation and the children currently growing up should be the main target for communicating knowledge on FGC. It is they who have to take the decision whether to circumcise or not in the future.

*d. FGC-activities*

Several activities targeting FGC eradication were mentioned. Radio, television and newspapers were identified by some organisation workers as mediums through which ideas about FGC eradication were communicated. The research assistant collected newspapers for a week and listened to the radio in the mornings for a period of approximately one month, but did not find anything. However, she claimed to remember that in the summer of 2010 there had been a lot of talk about FGC on the radio and in newspapers. She thought that this was due to international organisations, as when they left nothing more was heard in the media. However, many research participants claimed that girls were commonly circumcised during the school holidays in summer and therefore it may be that several campaigns deliberately target this period. Two of the medical facilities visited displayed posters showing the health complications of FGC (photos of some of these posters can be seen in the background chapter on page 7-8). Several organisations also reported using information and communications technology such as videos for training purposes and handing out booklets illustrating the issues of FGC.

Some of the people working within the health sector explained that they had learnt about FGC and its health complications on the job through seminars, trainings and workshops. Similarly, most nurses said that they had learnt about FGC through their formal medical education. One of the TBAs explained that she had received training from the Red Crescent and now counselled women on FGC issues at the MCH where she worked. Often mothers that came to her to circumcise their daughters requested the pharaonic circumcision. However, she would explain to them that she would only perform a minor cutting of the girl and give her one, or maximum two, stitches. She would explain how the religion bans pharaonic circumcision and allows only sunna circumcision. Often mothers would be convinced by this, but sometimes they got upset. The TBA explained that this created a difficult dilemma:

We say that's the type we do or you can leave. But we are sometimes worried to say that she can leave, because if she leaves she will go to someone else who does the type she wants.  
(TBA 5)

Many of the research participants explained that being a circumciser can provide a good income. For example, one housewife claimed that circumcisers earn approximately \$10 per circumcision, a not insignificant sum in Somaliland:

[N]ow they almost take 10 dollars to do the circumcision for the girl, so for them this is an income. (Housewife 9)

A research participant who worked for an INGO said that her organisation had tried giving circumcisers an alternative income. However, her INGO had realised that as long as the market for circumcision remained, so would circumcisers. She pointed out that circumcisers would stop circumcising while they had an alternative income, but quickly resumed the practice once this ceased.

Many of the lay people said that they had heard about FGC in speeches by religious leaders in mosques and in plays at theatres. One of the men explained that the first time he heard about female circumcision was in 2010, in a play at a student party:

I heard about it [FGC] on a theatre play at Ambassador Hotel in a student party. The students called some famous actors and they were acting about the problems of circumcision and how they have menstrual problems and things like that. (Male 14)

After he had seen the play he explained that he was convinced that FGC must stop and he wanted, in the future, to marry an uncircumcised girl.

While there is growing acceptance that pharaonic circumcision is not religiously sanctioned, religious ideas about sunna circumcision are more ambiguous. An organisation worker explained that her organisation had paid to send some religious scholars from Somaliland to Saudi Arabia to exchange ideas on FGC matters between religious leaders. This was done because FGC is not practiced by the majority population in Saudi Arabia. She explained that when the religious leaders came back they brought with them the idea that pharaonic circumcision was not a religious obligation, but that sunna was. In this way, she argued, they introduced the concept of sunna circumcision to Somaliland society.

Based on the current actions to implement a law on FGC, and the UNICEF and FGM/C-workshops, it seems that there has been a recent focus on improving coordination and collaboration between organisations working on FGC issues. Based on a report of a coordination and collaboration workshop held in June 2011 it seems that there is an emphasis on collecting statistics on the phenomenon as well as monitoring and evaluating FGC initiatives (Musse, 2011). One representative of a recently established local NGO explained that she wanted to contribute in the improvement of coordination of FGC initiatives and also that she wanted to create a resource library on FGC and reproductive health issues in her organisation's office. She saw the provision of data as crucial for organisations working on FGC matters as there was currently insufficient data on the prevalence and occurrence of health complications related to FGC. Another representative from an organisation explained that although workshops were useful,

there is also a need for public statements by politicians to ban the practice, as this was, in his view, not currently happening.

One representative of a local NGO explained that her organisation had future plans to hold discussions at schools and university campuses on FGC and to create community centres for girls. Discussing FGC would be part of the activities offered. Other organisations felt it best not to tackle FGC as a stand-alone issue as this may be viewed suspiciously by members of the public. They felt that they could be more successful in gaining the people's trust by integrating FGC initiatives into other programmes. For example, one person explained that their organisation had learnt that initiatives cannot target FGC directly and needs to be a component of a reproductive health initiative:

We are integrating FGM with other maternal health or safe motherhood issues because the people do not accept to talk about FGM alone. You have to do something first, and then you can integrate FGM with that. Then they will accept, and they will agree with what you say. (Organisation 4)

Eradication activities thus seem plentiful, and demonstrate that FGC is approached in new and diverse ways.

### **Ideas, opinions and understandings about eradication and abandonment of FGC**

Culture is not static, and in the case of Somaliland one can see this through initiatives aimed at eradicating FGC. It is therefore important to see FGC eradication as part of social processes that are continuously negotiated by a range of actors. This last section involves research participants' opinions and ideas about eradication campaigns and understandings of FGC abandonment. It identifies some of the challenges for eradication, but also some of the facilitators, and indicators of improvements.

#### *a. Religion*

Religion was given as a key reason by many of the lay people to abandon pharaonic circumcision. However, at the same time religious ideas were strongly used to justify the continuation of sunna circumcision. Most organisation workers explained that it is not a religious obligation to circumcise, but that in general lay people believe it is. The religious scholar interviewed explained that it is not a religious obligation, but one can interpret the religious writing in a way where the girl herself has the choice whether or not she wants to be circumcised.

Most research participants believed pharaonic circumcision was largely being abandoned in urban areas, and was increasingly being confined to rural and remote areas. For these participants it was clear that pharaonic circumcision was being disconnected from religion. Most explained that pharaonic circumcision was the result of cultural tradition and was not a religious obligation. For example, when asked about changes from the past to the present one midwife explained that now it is no longer a religious obligation to undergo circumcision:

I know some people who didn't do it. The only reason that makes all these people do the FGM is just because of the culture. Nothing else, except the culture. (Midwife 1)

It is not clear whether this research participant refers to sunna or pharaonic circumcision. However, in other interviews with lay people it is obvious that sunna circumcision is still culturally required and that it is also seen as a religious obligation. A male student, for example, explained that if sunna circumcision was not a religious obligation it would be stopped, but as it is it therefore needs to be continued:

People want to continue sunna because it's in our religion, and people like to do what is in our religion. If that thing is not in our religion they would not do it. (Male 16)

Another research participant, a housewife, explained that pharaonic circumcision used to be tied to religion, but not any longer. Sunna, however, is needed as part of female genitalia is viewed as 'haram' (illegal practice in Islam):

We do circumcision because we are Muslim [...], that part that they are removing during the circumcision is haram and they need to remove it because that's what our religion says. In the old days the Egyptian pharaoh, where the circumcision comes from, used to remove everything and close all of the area, stitch it all together but nowadays they are just going to remove that small area and do the stitches. (Housewife 8)

It seems clear that for many pharaonic circumcision is equated with something that happened in the past. According to research participants if pharaonic circumcision is still practiced in the present, it is only done so as a cultural practice and has nothing to do with religion.

During the FGM/C-workshop, the Ministry of Religious Affairs condemned the practice of pharaonic circumcision while claiming that sunna circumcision is still a religious obligation. One of the representatives of the Ministry explained that he had discussed sunna circumcision with several religious scholars, both in Somaliland and abroad, and that he had come to the conclusion that sunna is a religious obligation:

[Sunna circumcision] is something written in our religion and I asked a lot of sheikhs about this outside the country, even some of the biggest ones, [...], I researched a lot [...]. The ones who circumcise is the one who really follow the religion [...]. It is better [to do sunna circumcision] than not circumcising. (Representative of Ministry of Religious Affairs, FGM/C-workshop)

One of the representatives of the Ministry of Labour and Social Affairs challenged the view that sunna circumcision is commonly practiced outside of Somaliland. She argued that because the Middle-East is the origin of Islam, Somaliland should follow the religion as it is interpreted there. She claimed that the Quran should be interpreted as if female circumcision is not a religious requirement:

I think that the Arab sheikhs are better than us since the Quran in our religion is in their language [...]. In the Arabic language there is a word that has different meanings, [...] and it means that the Prophet said not to circumcise the girl. It means to do a circumcision for the boys not for the girls. (Representative of MOLSA, FGM/C-workshop)

During both workshops, but particularly the FGM/C-workshop, it was noticed that the religious leaders were accorded enormous respect. They cited the Quran at the beginning of the workshop and during the discussions it was noticed that if a religious leader or scholar wanted to speak everyone stopped talking and listened. This was not a courtesy shown to other individuals who attempted to break into the discussion. It was obvious that religious leaders or scholars are key actors in shaping and directing understandings of FGC and of abandonment.

*b. A move towards use of medical facilities and medical staff*

It seems that the phenomenon of circumcision is increasingly being understood in biomedical terms and practiced in medical facilities. Several research participants explained that in the past it was the norm for circumcision to take place at a family home. However, nowadays there are other options and many choose to circumcise their daughters at an MCH or in a hospital in addition to doing it at home. Several research participants claimed that circumcision is usually carried out by a TBA, a nurse or a midwife.

Several of the lay people interviewed highlighted differences between TBAs and circumcisers. A TBA was described as someone who is skilled and has medical equipment. Two research participants claimed that circumcisers traditionally belong to a minority tribe called Gaboye. Now, however, it seemed anyone who is a female could be trained to be a circumciser. A circumciser was described as someone who is not a health worker and who may use unclean equipment. In

addition, the skills of a circumciser are said to be passed down through the family, as opposed to being formally taught, and a circumciser often offers others services such as massages.

According to some research participants, as practices of pharaonic circumcision have come under criticism, using a circumciser is often something that is more secretive than it was in the past. One of the nurses explained that she thinks people are ashamed to come to the hospital if they have to show that they have complications related to the pharaonic circumcision.

In initial interviews focussing on the overall health context in Somaliland, a recurrent theme was the huge lack of skilled health staff in the rural areas. It is hardly surprising therefore that most respondents argued that practices of circumcision were less influenced by medical knowledge in rural Somaliland. As one of the TBAs who came from a rural area explained:

In the rural areas [...] they still know how to do that practice and to do the pharaonic type.  
(TBA 6)

One of the males claimed that in these areas circumcisers, rather than TBAs or other medical staff, are used. In the rural areas, it thus seems that practices of FGC are referred to as being in the past, while urban areas are doing modern practices.

However, it seems that circumcisers themselves are becoming more familiar with medical knowledge and procedures. One of the FGC activities mentioned by several representatives of organisations was the provision of training in health skills to circumcisers. One research participant explained how his aunt used to be a circumciser, but then became a nurse and is now engaged in fighting the practice:

My aunt was a circumciser in the rural areas in the old times. Later she came to the city and [...] she went to the nursing school and she became a nurse [...]. Now she is telling them how she used to circumcise girls, and she asks them not to do that. (Male14)

It therefore seems that through medical skills people may make a change and can support abandonment of the phenomenon, or at least promote less harmful practices.

### *c. Ideas about government involvement in FGC eradication*

There is currently no law prohibiting FGC in Somaliland and research participants had varying thoughts about the usefulness of such a law being introduced. One of the main concerns was that prohibition would not work in practice and would only serve to shroud the practice in more secrecy, thus making it harder to address the negative health consequences of the practice. In



addition, one of the men interviewed believed that FGC was a private matter and not something the government should get involved in. Another research participant from a multilateral organisation explained that issues in Somaliland are not solved by law as in the West, but in a cultural way by working through the tribal system. He thought that a law, as in the Western understanding of it, is not useful in Somaliland society as people do not see a value in it. The reason for this, according to him, is that laws traditionally have not worked in Somali society. Society has rather been organised and negotiated through clans and tribes. He suspected that a law would be counterproductive as it could be seen as a Western interference in Somali culture, and FGC could thus be used as a form of resistance to Western intervention. He and a number of other research participants from both organisations and lay people, however, emphasised that a law could work depending on the specifics of it. It was crucial that the law needed to be tailored to the people and culture of Somaliland.

*d. Barriers and challenges to eradicating FGC*

Several barriers and challenges to eradicating FGC were identified. As will be seen later, with the right approach some of these barriers can also become facilitators.

For many of the organisations, knowledge of FGC-related health complications was not the major barrier to FGC eradication. Many representatives of organisations claimed that knowledge of the health complications of FGC is widespread:

Everybody in the capital, everybody can state the complications. Everybody knows the problem of the FGM. Everybody can put name of the complications. (Organisation 4)

One of the beauticians agreed that in general people know a lot about the problems of circumcision, but insisted that there is not much change as some men still prefer to marry someone who has undergone pharaonic circumcision. Similarly, one of the housewives explained that people still want to circumcise so that their daughter does not become isolated in society. Several organisation workers explained that FGC is still a sensitive topic to address and because it is a deep-rooted cultural issue it is hard to approach in a culturally sensitive way and reach all actors in society. Although there is knowledge there, one representative of a local NGO explained that she thought most religious leaders would like her and the other activists “to just go away and not discuss the topic” (Organisation 13). Furthermore, elders have a strong position in society and often hold more conservative views in support of continuing the practice. It thus seems that knowledge of health complications of FGC is alone not enough to eradicate the phenomenon.

Coordination was mentioned as a huge challenge for several organisation workers. A representative of a multilateral organisation in charge of reproductive health explained that reproductive health initiatives were challenging to coordinate and highly fragmented:

[Multilateral organisation] is meant to be a coordinating body, but who is going to listen?  
Everyone is doing their own thing. They do whatever they like, to be frank. (Organisation 1)

Several organisation workers complained that there was a lack of effective leadership of FGC-work, and as a result campaigns designed to eradicate FGC were often unsustainable. One organisation worker explained that a body aimed at coordinating FGC initiatives was poorly managed:

You know we feel that, [local NGO] has not done a lot, as we expected from the management of it. There will be a meeting on the 12th to change the board and elect a new board and [...] maybe work on how the network will be more effective. (Organisation 15)

This research participant, however, believed coordination could improve by selecting a new board. A representative of a local NGO claimed that there are also very recent improvements in the coordination of reproductive health initiatives. She explained that donors, government officials and national stakeholders have realised that it is better to identify common areas to prioritise rather than working in isolation:

[...] inviting government officials and telling them let's sit together and let's see how we prioritise and where we work. Before everybody used to be stepping on everybody else toes.  
[...] I think it is positive. (Organisation 3)

There were also huge challenges with how organisations working to eradicate FGC actually monitored and evaluated the efficacy of their work. Several representative of organisations complained that there was a lot of talk in workshops on how to eradicate FGC, but that few actually did anything outside the workshop. One organisation worker explained that when she had started working in the government to mainstream FGC eradication she felt that there was a lack of direction, and when she asked those who worked with her for the overall aim of their FGC-work, no one knew. She said it was hard to introduce any laws or regulations on banning FGC as there was a lack of good quality data on the actual prevalence of the phenomenon. Another organisation worker explained that some of the activists often support sunna circumcision themselves and therefore it is hard to have a common stance in work aiming to eradicate circumcision entirely.

Another challenge that emerged was funding. A few, particularly government workers, complained that the lack of sustainability was a result of uncertainty and fluctuations of funding levels. One research participant explained that it was difficult for the government to make a sustainable plan as Somaliland, being an unrecognised state, did not receive sufficient multilateral or bilateral funds. A few international staff explained that the priorities of donors and competition for the funds meant that there were different motivations for doing FGC-work in Somaliland. It seemed that aid initiatives in general were often driven by donor priorities rather than by needs that emerged locally.

Several research participants explained that FGC-work has not always been prioritised as there are other more pressing challenges related to post-war reconstruction and development of Somaliland. One research participant working in a local NGO, for example, touched upon several other challenges related to providing reproductive health care:

You deploy people, you deploy equipment, you deploy drugs. But when that finishes up, everybody goes back. Then you are back to square zero. [...]. Education and health are the most expensive in all countries, all over the world. It's not only here. So imagine that in a developing country which is not recognised. That is quite a challenge. (Organisation 3)

There are obviously many complex processes of building a nation-state in a so called 'developing country'.

Although a change can be seen in the move towards the practice of milder forms of FGC, a few pointed out that there were challenges identified in the shift from pharaonic to sunna circumcision. When one of the beauticians was asked if FGC was easy to talk about between her friends and family, she explained that there is conflict between those that have undergone the sunna circumcision and those that has undergone pharaonic circumcision, and therefore it is not easy to talk about. She thought that the girls with pharaonic circumcision were stigmatised by young girls who supported sunna. She explained that this was because pharaonic circumcision was now looked upon as something that belonged to the past and was not 'modern'.

#### *e. Improvements and facilitators in FGC eradication*

The research identified several areas of progress in the push towards eradicating FGC. As already described, most lay people seem to be convinced that pharaonic circumcision is harmful and a number of participants wanted to make friends and family aware of the health complications of pharaonic circumcision. This may indicate that the FGC-awareness campaigns related to health complications have been effective. During the UNICEF-workshop several participants

emphasised the need to spread their activities outside of Hargeisa into rural and remote areas of Somaliland as knowledge in these areas is not as widespread. Some of the lay informants emphasised that people need to understand the reasons for stopping circumcising if they themselves are to abandon it. A female nurse/midwife explains that because of knowledge the pharaonic circumcision is stopped:

That's why they just stop doing the pharaonic and they go to the sunna type, they switch to that type because they want to stop [...]. The people on the rural area are not educated so they need more awareness and encouragement to know the health problems of FGM.

(Nurse/midwife 7)

In explaining that people in the rural area need more knowledge related to pharaonic circumcision (FGM in this quote seems to refer to pharaonic circumcision, not sunna) it appears that she believes that people in the city have abandoned pharaonic circumcision through knowledge of its associated health problems.

Many research participants mentioned that further awareness campaigns on the health issues of FGC would be positive, particularly in the rural areas. Some of the female research participants, for example, stated that they had gone through pharaonic circumcision, but due to the awareness-raising campaigns they had realised that girls did not have to go through these painful experiences and therefore they did not want their daughter to do the same. Several of the midwives and one of the TBAs mentioned that they had observed that women without pharaonic circumcision had easier delivery and they reasoned that this meant that sunna circumcision was much better. One of the housewives explained that she now understood that one was unclean due to urine and blood clots if the vaginal walls were fused. She argued that this was also bad on religious grounds as one needs to be clean in order to pray.

The claim that coordination and collaboration of FGC-work is improving reflects a shift in how eradication of FGC is understood. The FGM/C-workshop that was held in November 2011 shows that religious leaders consider FGC an important issue to debate. It also illustrates that there is a perceived religious significance of the phenomenon where religious leaders are considered key facilitators for eradication. The FGM/C-workshop concluded that there is a need to define and communicate what sunna is and is not.

Structures within society were looked upon as much as barriers as they were facilitators for change. One nurse/midwife explained that as a health worker it was easy to be against FGC and that few would criticise her if she did not let her daughter undergo circumcision (it is unclear

whether she referred to sunna or pharaonic circumcision). One of the housewives, who was herself in her 50s, thought that old mothers and grandmothers could be convinced that FGC is bad, and as they were well respected in society, they could influence the decision to circumcise girls in the younger generations. One beautician further illustrated the strong position of elders by telling the researcher to initiate more awareness raising campaigns:

I encourage you to do more awareness campaigns for the people, and specifically for the old mothers, because even the young mothers face some problems because they face pressure from the family and the relatives. (Beautician 10)

At the UNICEF-workshop it was emphasised that Islam bans any violence towards children, and therefore it is possible to argue that FGC, as a form of violence against children, should be banned. Furthermore, knowledge-exchange with religious leaders in other parts of the world may enable different religious understandings of the phenomenon to be accepted in mainstream Somali society.

The marriage preferences of males were identified by both male and female participants as potential facilitators of eradication. This was because marriage was seen as one of the reasons for circumcising. The government was by some looked upon as an institution to enforce laws to ban the practice. The education system and curriculum in schools were mentioned at the FGM/C-workshop as important new arenas to focus on when designing initiatives aimed at eradicating FGC. A few lay people were interested to hear from the researcher whether rumours that Somali girls were not circumcised abroad. It therefore may be that influences from abroad and the diaspora also are facilitators for eradication.

#### *f. The future of FGC*

As has been seen, there are several opinions on the impact of the FGC initiatives. What these changes mean or where exactly they will lead was unclear. However, almost all the research participants agreed that eradication, if it is to come, will take a very long time, at least a generation or two. Especially if one considers the rural areas.



## **Chapter 6: Understanding reality conceptions: A discussion of the findings**

Many elements related to the abandonment of FGC in Hargeisa are unknown. What appears clear, however, is that understandings of FGC are embedded in a complex web of perceptions – perceptions, for example, over what it means to be a Somali woman or a good Muslim; perceptions of women's sexuality and the relationship between women and men; perceptions over science and health; and perceptions over tradition and culture. This study is based on the assumption that efforts to eradicate FGC need to be conducted in a culturally sensitive way that values a diversity of worldviews. It recognises that 'culture' is not bounded by a common identity in which all individuals adhere. However, it insists that a 'collective consciousness' is powerful in the construction of knowledge within a culture (Anderson, 1983).

FGC and abandonment of FGC are defined and described in Hargeisa in both contradictory and complementary ways. The different explanations of FGC and abandonment presented in this thesis illustrate perceptions of a 'reality' that is constantly negotiated through different social mediums and institutions. It is fundamental to critically analyse these reality conceptions to better comprehend what FGC is, or could be. The following presents an analysis of different aspects of FGC, illustrating that understanding reality conceptions of the phenomenon provide a useful toolkit for approaching eradication of FGC.

### **The biomedical discourse of FGC**

When the international community first responded to FGC, abandonment was framed according to a biomedical perspective (Toubia & Sharief, 2003). In efforts to eradicate the phenomenon, the medical disadvantages of FGC were emphasised and as a result most populations where FGC is practised are now aware that FGC can be a health problem (Talle, 2010; WHO, 2011b). The findings of this study confirm this view in that all research participants could name health consequences of pharaonic circumcision and most explained that these consequences can be harmful. The previously discussed posters and counselling on the harmful effects of pharaonic circumcision in medical facilities exemplified how eradication of FGC is approached through a biomedical discourse. One implication of this is that in Hargeisa health care workers are increasingly being used instead of circumcisers. Following Talle (2010), medicalisation of FGC can be seen as a process whereby skilled midwives, nurses, doctors and other health staff use modern drugs and equipment when conducting the operation. Medicalisation of the phenomenon has shifted FGC from a discourse based purely in tradition, culture and religion to one that is based, at least in part, on biomedical science.

Foucault's interest in the power/knowledge nexus is useful when assessing medicalisation of FGC. Foucault's understanding of how knowledge operates as power is based on historical enquiry into previous forms of human subjectivity. He argues that most historical analysis is concerned with continuities between the past and the present. Foucault's approach on the other hand, is more concerned with locating "discontinuities" (Burrell, 1988, p. 224). For Foucault periods with major discontinuities mark the boundaries of different 'epistemes'. Epistemes are the deeper structures of knowledge which make "possible the separation, not of the true from the false, but of what may not be characterised as scientific" or acceptable knowledge (Foucault, 1980, p. 197). Thus, Foucault sees society and culture as 'discursive formations' in which human beings are made subjects (Foucault, 1980). The "ensemble of ideas, concepts and categories" that we use to understand reality – especially those elevated to the status of science – organise power and thus in a sense create reality (Foucault as cited in Hajer, 1993, p. 45). By arguing that knowledge and power intrinsically belong together it is possible to argue that culture and society are constituted by the ideas, concepts and categories that are defined as 'truth' at a given time. Subsequently, society and culture are imprisoned by the limited sets of categories offered by certain types of knowledge that characterise an episteme. Nonetheless, a break from one episteme to another involves the elevation of a new public discourse of 'truth', making social change possible.

This study has shown that FGC was described as previously being understood as a phenomenon embedded in culture. Traditionally, circumcisers hold a position of respect in Somali society, but usually have no health-related education (Talle, 2010). In the past it was predominantly circumcisers with no health education that conducted the procedure, often using sticks and thorns as instruments. The circumciser usually visited someone's home and conducted the procedure there (Talle, 2010). However, as campaigns to eradicate the issue have publicised the health complications of FGC, a discontinuity is established in how FGC is understood and practiced. During the last years people have increasingly started to use medical facilities to undergo the procedure using sterile equipment and anaesthesia rather than inviting circumcisers to their houses (Talle, 2010). In Hargeisa, people describe that they understand FGC differently to how they did in the past, and many now claim to make use of medical professionals, medical facilities and medical equipment when undertaking the procedure.

However, medicalisation may not be an entirely new change, as Talle (2010) reports that the use of medical staff was already occasionally occurring in the 1950s in Mogadishu, the capital city of Somalia. Although this study cannot account for what 'truth' constituted fifty years ago, and if



there has been a change, it is obvious that FGC in Hargeisa is currently being framed within a biomedical discourse and that people claim that this is different to how it has been understood in the past.

From a Foucauldian perspective it therefore becomes evident that the way people understand themselves and practices of FGC are constituted to some extent by the creation of rational, scientific knowledge. FGC is increasingly part of a biomedical discourse, and thus a biomedical understanding of FGC as 'acceptable' knowledge is being constructed. By framing FGC as a biomedical issue a powerful discourse of truth appears where subjects act according to what is rendered 'true'. As the data show pharaonic circumcision is increasingly being considered as a practice of the past that people with 'modern' ideas will not let their daughters go through. In viewing medicalisation as an influential discursive formation one can see that social change is enabled, and abandonment of FGC made possible.

While scientific, medical knowledge has undoubtedly helped to shape changing perceptions of FGC, a sole focus on the biomedical aspects of FGC has recently been criticised by academics (Toubia & Sharief, 2003). The criticism of approaching FGC as a purely biomedical issue is based firstly on the fact that although the severity of the practice may have been reduced, little progress appears to have been made in reducing prevalence rates (Black, 2010). Secondly, conceptualising FGC in biomedical terms may simply legitimise procedures that are conducted within a medical environment rather than leading to a reduction in the phenomenon. It is apparent that while circumcisers are getting less popular, a range of people can now gain the skills or the status as someone who can rightfully circumcise. Thirdly, medicalisation implies that the practice is undertaken in a 'safe' environment. It means that the risks of complications such as infections due to using unsterile equipment and the trauma of the girl without anaesthesia are reduced (Talle, 2010). However, by medicalisation of FGC there is a risk of further institutionalising the practice, thus making FGC acceptable and encouraging its continuation (Talle, 2010). Moreover, modern medical equipment is viewed as more efficient than traditional methods. Pain-relief, for example, may mean that the girl does not scream or struggle as much as in the past. The net result of this may be that it becomes easier to access and cut more tissue than it has been in the past (Talle, 2010; WHO, 2011b).

It is claimed that there has been a trend towards milder forms of FGC in countries where medicalisation is apparent (Talle, 2010). Consequently there has been recent debate over whether a policy of total eradication or one of promoting medicalisation and milder forms of FGC is the best way to address the practice (Talle, 2010). Some critics argue that the aim of totally and

rapidly eradicating the practice creates resistance in target populations, something which can be exacerbated when foreign actors fail to pay due consideration to the lived ‘realities’ in communities practicing FGC (Obermeyer, 1999; Talle, 2010; Toubia & Sharief, 2003). However, promoting milder practices is not without criticism too as it may in fact reinforce it as a safe and legitimised ritual. It has thus been argued that a more holistic approach, which sees FGC as much as a social issue as it does a health issue, is needed. In Somaliland, for example, it is the Ministry of Labour and Social Affairs that deals with FGC-related policies rather than the Ministry of Health (Ministry of Labour and Social Affairs, 2011). This does not necessarily mean that the health complications should be neglected in abandoning FGC, but rather that there is a need to acknowledge the limitations of a pure biomedical approach and to consider the broader social context in which FGC occurs.

As shown in the findings, three approaches to approaching FGC were identified seeing FGC as a: (1) Social or cultural issue; (2) human rights issue; and (3) medical issue. It is important to note that neither of these philosophical approaches is mutually exclusive. It is, for example, quite possible to frame FGC as a social and cultural issue as well as a medical issue. However, to a certain degree each of these approaches can involve the empowerment of a different set of actors as well as the legitimisation of a set of preferred practices. While some organisations remain steadfast in their total opposition to all forms of FGC, other organisations take a more pragmatic approach, looking at ways in which practices of FGC can be altered to reduce the harm to women and children. Viewing FGC primarily as a human rights issue involves looking beyond FGC as a single isolated issue and instead seeing it in relation to a broader set of supposedly universal rights. An advantage of this approach is that these rights have some basis in international law. However, the legal foundations of such an approach are less clear in Somaliland where a key pillar of international law – sovereignty – remains unrecognised. By actively involving the Ministry of Religious Affairs and religious leaders, for example, the FGM/C-workshop is trying to bring about new understandings of the phenomenon through a religious lens.

### **Religion: A crucial part of a collective consciousness**

As the data showed, a key justification for letting girls undergo sunna circumcision in Somaliland is that it is a religious obligation. Some of the research participants explained that parts of the female genitalia, such as the clitoris, is considered forbidden in Islam and therefore needs to be removed. On the contrary, the data illustrated that in Somaliland it is accepted that pharaonic circumcision is not a religious obligation, but rather a religious offence.

The FGM/C-workshop illustrated that in Somaliland it is currently debated whether sunna circumcision is a religious obligation. As has been seen, the Ministry of Religious Affairs in Somaliland insists that sunna circumcision is a religious requirement and should be continued. However, counterparts, such as the Ministry of Labour and Social Affairs and the Ministry of Health and Labour, claim that sunna circumcision is not a religious obligation, and that girls should therefore not be circumcised at all.

As Islam is the main religion in Somaliland, it thus seems useful to look briefly into how FGC is understood in Islam. Abu-Sahlieh (1999) explains that the holy book used in Islam, namely the Quran, is believed to have been written by God. The Prophet Muhammed is considered to be the messenger of God and the concept of ‘Sunnah’<sup>3</sup> refers to sets of writings supposedly written by the Prophet Muhammed (Abu-Sahlieh, 1999). These sets of writings are commonly used to interpret the Quran. However, many religious scholars are critical of the authenticity of these writings (Abu-Sahlieh, 1999). Abu-Sahlieh (1999) explains that in the Sunnah-writings male circumcision is referred to as ‘sunna’ and female circumcision as ‘makrumah’. He goes on to explain that the term sunna in reference to male circumcision means “something that conforms to the tradition of Muhammed himself” (Abu-Sahlieh, 1999, p. 147). However, it can also be interpreted to mean “a custom at the time of Muhammed” (Abu-Sahlieh, 1999, p. 147). In other words, it is not clear whether references to male circumcision are descriptions of the past only or whether they are something that one should continue to do now in order to follow the tradition of the Prophet Muhammed (Abu-Sahlieh, 1999). ‘Makrumah’ or female circumcision, on the other hand, can, based on the Sunnah writings, be interpreted as something that one can choose to do, but which “is not obligatory from a religious point of view” (Abu-Sahlieh, 1999, p. 147). It thus seems fair to argue that FGC is not a religious obligation based on the teachings of Islam. However, as this study has shown, it is a point that remains highly contested.

It is at this clash of religious confusion that present day Somaliland exists; some argue that sunna circumcision is a religious obligation, others that it is nothing but a perceived cultural necessity. Either way circumcising females is ultimately tied to ideas of a common social identity. The idea that we live in various “imagined communities” has been used by Anderson (1983, p. 1) to describe the constructed national narratives which powerfully shape people’s collective consciousness. Rather than nationalism and national myths describing an external reality, they actually bring national identity into being (Anderson, 1983). While Anderson was describing the

---

<sup>3</sup> In the case of referring to the religious writings the term ‘Sunnah’ is used as this is how the author uses it (Abu-Sahlieh, 1999). As ‘Sunnah’ in this case refers to sets of writings by the Prophet Muhammed, it is therefore not related to sunna circumcision.

formation of *national* identities, many of the same processes apply to other forms of collective identity. Akou (2011) explains that in recent years Somalis in exile, in Somaliland and Somalia dress more conservatively than the past arguing that it is a reflection of Islam becoming stronger amongst Somalis than in the past. Talle (2008) suggest that this changing way of dressing may be a substitute to circumcising, and is used as a new mechanism to create a common Somali identity that exists across borders. This implies that abandonment may not be about circumcising per se, but rather it can be part of constructing and reconstructing a common identity. In contemporary Somaliland practices of FGC need to be understood in relation to the processes of constructing collective identities as well as taking account of how people understand their own behaviour according to the characteristics and behaviours of the imagined communities to which they feel a part.

Anderson (1983) argues that dominant discourses shape collective consciousness in powerful ways. Many participants felt that one was not a complete woman without having undergone FGC. For these people the phenomenon can therefore be seen as an essential part of a common identity (Talle, 2010). Collective identities are extremely powerful in justifying, sanctioning and promoting certain characteristics or practices, just as they are powerful in condemning and restricting others. This is not, however, to say that individuals necessarily identify themselves with this as an uncontested or unified group (Spencer, 2008). Practices of FGC are not above or external to society. They are constantly maintained and negotiated by the actors who feel they are a part of a larger whole, often as a result of being exposed to external ideas and influences. However, this is not to suggest that people have no agency and are solely the products of forces beyond them. 'Agency' refers to the ability of an individual or group to influence the conditions and opportunities of their life in the past, the present and future (Ortner, 1995). As the findings show, mothers were perceived to be the decision-makers when it comes to a girl's circumcision. One way of abandoning the practice may thus be for mothers to not allow their daughters to be circumcised. According to Ortner (1995) the result of agency might be the reconstruction of society and it might be the reconstruction of the self. In other words, if a mother decides not to circumcise her daughter, she has broken down a well-established aspect of her collective identity. Her daughter then symbolises a reconstruction of this identity in new ways. In this way, an individual can use his or her agency to challenge structures in society and one's own place within it.

However, well-established structures in society may also challenge an individual's agency and result in a continuation of his or her life without changing one's life conditions (Ortner, 1995). As

was found in this study, decision-making is not only dependent on mothers. Other social actors or institutions, such as grandmothers and religion, may strongly influence the woman's decision. The problem of structure demonstrates the challenging interactions between structure and agency. Subsequently efforts to abandon FGC need to contemplate how social and cultural organisation is influenced by complex processes of collective consciousness as well as individual agency.

Key elements of cultural discourse such as language and religion are potential fault-lines in a collective identity which may result in the destruction or reconstruction of collective identities. As a result people often seek to defend these elements from perceived threats. Talle (2010), for example, reports that a community in Kenya adopted more severe forms of circumcision as a result of eradication campaigns in other parts of the country. This is, she argues, done to ensure they do a 'proper' type. Feeling that their collective identity was to some extent at risk, the adoption of more severe forms of FGC therefore became a form of resistance to outside influence. From this perspective the maintenance of FGC can be seen as a form of resistance to ideas and actors that are seen as external and potentially threaten these collective identities. The findings of this study indicate that a law to ban FGC is not welcomed in Somaliland as it is often perceived as an attempt to impose Western values.

Further this study has found that religious leaders are identified as extremely powerful social actors, and key agents for the continuation of sunna circumcision. Religious claims and agents are thus powerful in creating and shaping collective consciousness and countering external threats to a common identity. It can thus be counterproductive to intervene without recognising the realities as experienced by those in the concerned populations. This means paying close attention to the factors shaping collective identities.

However, it also means being aware of their potential for facilitating reconstruction of identity. It can be argued that current religious ideas are used to justify sunna circumcision. Subsequently if these ideas change, sunna circumcision can be looked upon as something 'cultural' which is not required. It is clear that religion can be a powerful driver of social change. This study has shown that in Somaliland pharaonic circumcision is being rejected and that religious leaders have played an important role in this by publicly acknowledging that it is not sanctioned religiously. It is evident in the data that religious leaders in Hargeisa are currently debating and negotiating what sunna circumcision means and how it should be seen in relation to religion. The outcomes of this will be highly influential in the future of FGC and those seeking to eradicate the practice need to be acutely aware of religion's potential to offer both resistance and support to efforts aimed at FGC eradication.

## Abuse and use of terminology

A recurrent theme in this thesis is that FGC in Somaliland is not clearly defined. Without an understanding of how it is defined and what it involves, it is therefore easy to reach false conclusions about practices of FGC. This study shows that people in Somaliland tend to conceptualise circumcision as either pharaonic or sunna. However, how these are defined and practiced remains far from clear.

As the data shows pharaonic circumcision is usually translated to English as Female Genital Mutilation, or simply as the acronym 'FGM'. This translation of the phenomenon is also evident in a recent promotional movie by an INGO which has run a project in Somaliland (Totsan, 2011). The movie claims to demonstrate a successful project proving that *FGM* is being abandoned in Somaliland. The movie uses 'FGM' in English subtitles to translate pharaonic circumcision (i.e. not sunna) as used by the people speaking Somali in the movie (Totsan, 2011). In other words, it is the abandonment of pharaonic circumcision, not all forms of cutting female genitalia, that is evident. English speakers without knowledge of the Somali language may assume, based on the international discourse of FGC, that 'FGM' refers to: "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO, 2011b, p. 1). Pharaonic circumcision as described in Somali, however, can be defined as infibulation only. By using the acronym FGM in Somaliland one fails to recognise the diversity of practices apparent. The understandings of FGC in Hargeisa and of FGM in the international community complicate knowledge on eradication of the phenomenon.

New terminology or increased clarity around usage of key terms when referring to practices of FGC in Somaliland is acutely needed. The understandings of FGC terminology in both Somali and English needs to be understood in order to get a clearer idea of what FGC actually constitutes in Somaliland. If no such understanding of terminology is considered it seems that abandonment of FGC is a blind path. One cannot make the straight-forward assumption that 'FGM', i.e. Female Genital Mutilation, equals all kinds of cutting of the female genitalia as it obviously does not in Somaliland. In the same way, what sunna circumcision is, or can be, needs to be clearly defined. It seems that sunna can be defined as anything from a small prick of the clitoris to practices that are as severe as some of those described as pharaonic circumcision (Talle, 2010). This study has found that the focus of the drive to eradicate FGC in Somaliland seems to have been on the eradication of *pharaonic* circumcision, not sunna. Due to use of terminology whether this is intentional or not is not always clear.

What is clear, however, is that normalisation of FGC-practices is apparent in Hargeisa. There seems to be a general abandonment of pharaonic circumcision as few want their daughter to undergo the procedure. At the same time, sunna circumcision is in general accepted and viewed as a cultural or religious requirement (Ismail, 2009). ‘Dividing practices’ is a concept used by Foucault who argues that by classifying and giving certain knowledge the status of science, a discourse of ‘truth’ is created. In turn this has the effect of normalising actions of a majority of people by defining certain acts, those that are not scientifically true, as abnormal. In the process of categorising ‘abnormality’ a discourse of ‘normality’ is also produced (Foucault, 1980). In this way the identity of a particular group is defined by what lies outside that group, i.e. ‘the other’ (Danaher, Schirato, & Webb, 2000). The findings of this study indicate that there is solid knowledge of medical complications and treatment of pharaonic circumcision in Hargeisa and many of the arguments for abandoning pharaonic circumcision were grounded in biomedicine. This study also found that pharaonic circumcision can be viewed as something that only ignorant people do; something which also does not correspond to ‘modern’ ideas of what is acceptable practices. Through a biomedical discourse pharaonic circumcision has thus been classified as harmful, and one can claim that in Hargeisa pharaonic circumcision is becoming ‘abnormal’. Sunna circumcision, on the other hand, seems to be understood as a ‘normal’ characteristic of a discursive truth in Somaliland. However, as this study has found, sunna is not easily defined. This may be an unintended result of ‘normalisation’ where pharaonic circumcision has been produced as harmful. Nonetheless, despite the definition of sunna circumcision not carrying a general consensus, characteristics of acceptable FGC in Hargeisa can be viewed as what is *not* pharaonic circumcision, and this is indeed referred to as sunna. Sunna circumcision thus has the potential to be different to pharaonic circumcision, and to some extent it appears to be.

Notably, sunna circumcision seems to have been ‘invented’ in the 1990s at the time when the international community deemed FGC a breach of human rights, and at the time when Somaliland declared its independence. Currently, sunna circumcision can be defined and classified as scientific, or ‘truthful’, knowledge grounded in religion. Still, in Hargeisa a total rejection of FGC is not present. What is present is an understanding that seems to be in contrast to the past where pharaonic circumcision is ‘abnormal’, and sunna circumcision to some extent ‘normal’. In this way sunna circumcision can become an essential part of Somaliland identity and culture. However, it is something that is still being actively negotiated.

## **Gender roles in the sunna generation**

Age is crucial in determining FGC prevalence rates and the future of FGC (Diop & Ba, 2004). As eradication of FGC involves generational change it can be assumed that it is not a short-term project with a start and finishing date – rather it is an extended and complex process. Therefore it is important to look for patterns or discontinuities when looking at different age groups. A rejection of pharaonic and acceptance of sunna circumcision indicates that there is a move towards milder forms of FGC. Up-to-date prevalence rates of FGC in Somaliland are unknown, but it is widely believed that the new generation of mothers-to-be prefer to let their daughters undergo sunna circumcision, if any circumcision at all (Baruud, 2008; Ismail, 2009). This generation can therefore be referred to as the ‘sunna generation’. There also seems to be a social divide between the girls that have undergone pharaonic and those that have undergone sunna circumcision. Sunna is to a large extent looked upon as a modern practice and it is perceived to be good to undergo sunna circumcision. Pharaonic circumcision, on the other hand, implies something negative which belongs to the past or to the rural areas and is, at least in Hargeisa, often viewed as unacceptable.

This study has found that not only does the sunna generation refer to circumcision in a new way, it also brings a new meaning to established FGC-practices by challenging perceptions of traditional decision-makers in Somaliland bringing about ‘new’ facilitators for abandonment.

Sex is a biological concept; one that carries biological characteristics that either defines you as a female or male at birth. Gender, however, is socially constructed, and what constitutes male and female is negotiated within society and varies across societies (Gove & Watt, 2000)<sup>4</sup>. It is for instance clear from this study that people have different responsibilities depending on their socially defined gender role. A female in Somaliland, for instance, carries different responsibilities and power in FGC decision-making depending on her potentially multiple identities in different social settings. She can, for example, be: A girl; a mother; a wife; a grandmother; a close relative; a distant relative; an NGO worker; or a health worker. Traditionally in Somaliland, circumcising females has been seen as a female-only ritual, while male circumcision is for males only.

Previously, males have not known much about the phenomenon of FGC as it was not seen as their domain (Johnsdotter, 2008; Talle, 2010). Talle (2010) and Johnsdotter (2012) claim that FGC in Somalia is a ritual that only involves women and that men have little influence on the decision-making. This is partially supported by the findings of this study, which show that most

---

<sup>4</sup> This thesis acknowledges that gender can be more complex than a simple male/female-binary. However, in the context of the argument presented it is not rendered useful to dwell further on this issue here.



participants believe it is the mother who should decide what or whether her daughter should undergo FGC.

However, as practices of FGC are changing, the sunna generation seem to have a different understanding of FGC than the older generation. As a result of the awareness-raising campaigns and people talking about the issue, general knowledge on how FGC is practiced is growing among the whole population and gender roles may be undergoing changes (Gulaid, 2008). This study found that there were several deviations from the commonly established idea that women were decision-makers when it comes to letting their daughter undergo FGC. It turned out that other social actors, such as fathers and husbands, are influential in decision-making. Some of the male research participants, for example, insisted that they themselves could choose to marry an uncircumcised girl or to tell their wives not to circumcise their daughter if they were to have one. Due to the campaigns designed to eradicate FGC, males in the sunna generation are more aware of what their potential wife or daughter will go through, and some claim to have realised that this is not something women need to endure. It is this realisation that demonstrates an alteration in what being a male constitutes in Hargeisa.

By altering male gender roles, assumptions of what female gender roles constitute can also be brought into question. It becomes apparent that it is not simply the mother who makes the decision of her daughter's circumcision. Men should not be a missing component in FGC-campaigns as they are just as much part of a negotiated culture which may bring new discursive truths of a lived reality into being. It is found in this study that men are potentially powerful decision-makers in female matters, such as whether their wife or sister should receive medical treatment. If a man is made aware of his potential role in the decision to circumcise, it is apparent that he can play an important role in whether a girl is circumcised or not. Some of the secretive female and male rites might break down if gender roles are scrutinised. It is therefore useful to understand the meaning of gender roles in Somaliland society and to acknowledge that social and cultural organisation is flexible. Through the sunna generation the construction, or rather reconstruction, of gender can be a powerful agent for change.

### **FGC and the construction of knowledge**

By unmasking “previously hidden mechanisms of domination and discipline” in a Foucauldian sense, it becomes evident that there is a well-accepted ‘truth’ in the international community that FGC is highly prevalent in Somaliland, and that it needs to be eradicated (Pickett, 1996, p. 445). There are not many reports found on FGC prevalence in Somaliland, but those found claim FGC prevalence rates of 90 per cent or above (Baruud, 2008; Black, 2010; Ismail, 2009; MICS, 2006).

It seems that the literature favours the assumption that FGC exists in large numbers at a global scale without really basing this on verifiable figures (Obermeyer, 1999). However, there seems to be geographic limitations to all of these reports, a distinction between the sunna and pharaonic type is rarely described and it is not clear what methods are used to collect the data. It thus seems natural to question how the prevalence of FGC is recorded in these studies and how they are conducted.

Lewis (1995) states that the only way to accurately determine prevalence rates is by conducting a physical examination of every girl who is at risk of circumcision. Nonetheless, even if this is done it can be hard to determine whether she has undergone circumcision or not. Additionally, it can be hard to determine what type of circumcision the girl has been subjected to as tissue grows (Johnsdotter, 2008; Talle, 2010). Obermeyer (1999) argues that very few of the supposed health complications of FGC are backed up by solid evidence and some of it, which gains very little attention, actually concludes that one cannot know if the supposed health complications relate directly to FGC. Ultimately then, it seems that one has to accept that there are gaps in our knowledge on FGC which may never adequately be filled (Obermeyer, 1999).

One should, nonetheless, question why the assumption of widespread practice of FGC is privileged over the view that FGC is decreasing. It also seems worth assessing whether the health complications of FGC match reality, and what that may imply. This, however, goes beyond the scope of this thesis. Nonetheless, it is insisted that the so called 'truths' of FGC need to be questioned in order to get a comprehensive understanding of the issue at hand. Several studies show that people in Somaliland can name a range of health complications caused by pharaonic circumcision, and so did research participants in this study (Baruud, 2008; Diop & Ba, 2004; Gulaid, 2008). However, very little is known about the complications of sunna circumcision. This study found that sunna circumcision is often looked upon as a desired practice with no health complications, even by some anti-FGC activists (UNFPA, 2007). There seems to be a general lack of understanding of what FGC eradication should be among organisations working towards eradication in Somaliland. This may be related to the claim, at least when referring to the past, that the coordination and collaboration between the different organisations is poor (Musse, 2011).

By looking into motivations for doing FGC-work it appears that there may be perceived benefits to frame FGC as a problem to a Western audience. The findings showed that among a few of those interviewed there is awareness that if FGC is seen as a problem, a Western-driven initiative will then put money into it. If more individuals carry this view, it may be challenging to determine the extent of FGC and associated health issues, at least for a foreign researcher. The way

knowledge has been communicated to the researcher in this research project constitutes a certain constructed knowledge on FGC and highlights a crucial, but often neglected limitation in understandings of FGC (Talle, 2010). Cautiously, one may argue that there is a financial stake in framing FGC as a larger problem than it is. Put crudely, it can be a money-winner that is impossible to track. Talle (2010) describes a workshop which recently took place in the Netherlands. In this workshop a participant asked why so little research focused on those women who were from FGC-affected populations but who had *not* undergone FGC. The answer she was given can be summarised as saying that if one found out that they are all uncircumcised there is no problem to be solved, and no money to be used.

Obermeyer (1999, p. 79) has conducted an analysis of FGC literature in order to identify “commonly accepted ‘facts’” on prevalence and harmful effects of FGC practices. She concludes that there is insufficient evidence on the actual complications of FGC and often studies proving a causal relationship between FGC and medical problems rely on faulty data collection methods and are thus unreliable. These studies commonly only have a few questions related to FGC and FGC complications as part of a larger demographic survey. According to Obermeyer (1999) this is faulty as there are no efforts to systematically measure complications that are a direct result of FGC. She insists that further research on the actual health disadvantages is needed “making it possible for people who are affected by the practices to make informed choices” (Obermeyer, 1999, p. 97). Although efforts in recent years are made to improve cooperation between activists and researchers and to produce better research, the data on prevalence of FGC is still often of poor quality and much of the statistics are based on anecdotal evidence only (Obermeyer, 1999). Global FGC prevalence rates should thus be treated as an indication, rather than as an established fact.

Having said this, however, it is clear from the way FGC is described that some form of FGC does exist in Hargeisa. It is clear based on descriptions made by *all* research participants that sunna circumcision (whatever that may be) exists in Hargeisa. Knowledge on the practice and the supposed health hazards of pharaonic circumcision, as well as changes in the practice, are also apparent. Thus this study found that there is ‘knowable’ knowledge about FGC, such as the use of terminology, reasons for still practicing FGC and opinions on eradication (Obermeyer, 1999). It has found that some of the people working on FGC find that coordination of FGC initiatives is improving and that part of the supposed lack of direction and ‘poor’ FGC-work is a result of rehabilitation after war. By improving coordination and collaboration of FGC initiatives, as some

of the research participants proposed, coordination and collaboration may become facilitators for eradication, rather than barriers.

It may be that through more targeted FGC work and improvements in coordination and collaboration previously 'hidden truths' about FGC, such as prevalence, will come to the fore. However, it is nevertheless crucial to realise how knowledge is constructed in order to tease out what can be rendered as 'truthful' knowledge. Additionally, it seems important to consider how FGC plays out in world constructed by a multiplicity of processes which indeed organise culture and society.

### **Eradication of FGC is not just a story of vaginas**

In some feminist literature it is argued that even when FGC only exists in a mild form and with few proven health disadvantages, it is a breach of human rights and a discrimination against women (Hosken, 1976). In the same way it seems far-fetched and far from useful to argue that FGC does not exist, or that it is not harmful. However, both arguments seem too simple in that they do not consider broader and more complex social issues affecting the concerned populations. This study found that eradication of FGC is not necessarily a priority activity for Somalis, and that particularly rebuilding Somaliland after independence and war has been a main priority. Therefore one has to realise that eradication of FGC is only one of the many small pieces that constitute a bigger and more complex puzzle of 'development'.

Development is a complex and contradictory term that is said to embody "both the best and the worst of human projects" (Peet, 2005, p. 2). The meaning of development is negotiated at various sites in society and our personal lives. As it is dynamic it does not have a fixed meaning and may change over time (Peet, 2005). Similarly, it is commonly accepted that 'culture' is not static, rather it is multifaceted processes at global and local levels that constitute culture (Bodley, 2005).

Western thought is dominated by binary thinking (Gardner, 1973). Binaries such as 'developed' and 'underdeveloped', 'modern' and 'traditional', 'urban' and 'rural', 'uncircumcised' and 'circumcised' are common ways of thinking in relation to global development. However, often these binaries indicate inequality as one binary is generally privileged over the other (Saul, 2004). International development organisations, for instance, play a major role in labelling and defining social and cultural organisation at an international scale and thus influence what 'we' (the 'developed') and the 'other' (the 'underdeveloped') understand development, or FGC, to be (Rosalind & Moncrieffe, 2006). Development often identifies problems to solve and, at least in the past, attempts to change them through 'modernisation'. It is claimed that Truman 'invented'

development insisting that poorer countries needed to be developed through modernisation and industrialisation where Western technology and ideals were seen as the desired goal (Rist, 1997). This understanding of development has later been referred to as “the new religion of the West”, and has been heavily criticised (Rist as cited in Pieterse, 1998, p. 360). It is increasingly argued that one need to look in new directions to value the diversity of worldviews.

When it comes to FGC then, it may be easy to believe that eradication of FGC is a straightforward path with prevalence rates steadily decreasing as ‘under-developed’ societies encounter ‘development’. Of course, this might be partly true. However, this assumption is in this study questioned as some (albeit questionable) data show that the current prevalence rates in Somalia are the same as 30 years ago (Black, 2010; Ismail, 2009). FGC is a strong cultural practice where one cannot easily provide a prescribed recipe for eradication. It is in the drive to eradicate FGC that universal ideas of human rights conflict with ideas of cultural relativism (Lewis, 1995).

FGC is definitely not the only concern for improving the quality of life of individuals living in Somaliland and as such may not always be seen as a high priority. It thus seems that FGC eradication must be seen in the broader context of Somaliland’s recovery and development. This means taking seriously the complex cultural, social, economic, global and local contexts in which FGC occurs (Rist, 1997).



## **Chapter 7: FGC and eradication: Reality conceptions matter - Conclusion**

There seems to be near universal consensus in the international community that FGC must be eradicated. However, after 30 years of attempting to eradicate the phenomenon it still appears to strongly persist. At the same time current FGC prevalence rates at a global scale are highly contested. Eradication of FGC is thus not easily divided into a black/white perspective where eradication follows a steady decrease in prevalence rates. One may never know the ‘truth’ of FGC, and absolute truth does not seem like a feasible goal in itself. Rather, uncovering contextualised social knowledge about FGC seems crucial in order to comprehend the issue at hand. By questioning well established assumptions surrounding FGC one can look into eradication of FGC in a more open way before arriving at a conclusion.

FGC is a practice strongly embedded in social and cultural understandings. Questions of eradication therefore invoke broader debates between universal ideas of human rights and ideas of cultural relativism. Recently, it has been increasingly argued that there are different paths to eradication depending on the social and cultural context of the group practicing FGC, and that a holistic approach is needed (Tiilikainen & Johansson, 2008). Furthermore, one can see that emphasis has been put on Somali culture as diverse including; Somalia, Puntland, Somaliland, and the abstract idea of ‘the Somali diaspora’. It should thus be obvious that eradicating FGC is more than a story of vaginas only (Gele et al., 2012; Talle, 2010).

This study did not aim to provide a solution to issues of FGC, nor did it aim to argue for or against eradication approaches. Rather, it insists that one of the major challenges to eradicating FGC concerns a complex question of reality conceptions. It is these reality conceptions that have been described and analysed in this study. This has been achieved by letting a diversity of people express their thoughts and opinions on FGC, and on initiatives designed to eradicate FGC. These people include individuals who work directly to eradicate FGC, health workers and those that have no professional understandings of the phenomenon. It is insisted that every attempt should be made to try to understand how different people, including the researcher, make sense of the issue. Thus an underlying notion of this thesis is that FGC must be approached in a culturally sensitive way that values a diversity of worldviews.

Although the reasons for continued FGC are not always consistent, it is a practice strongly embedded in religious and cultural understandings. What became clear in this study is that current understandings of FGC are described differently to those of the past. However, the idea that some form of genital cutting is necessary remains. This changing understanding of FGC can

particularly be seen through the fact that FGC is increasingly understood within a biomedical discourse, through changing understandings of gender roles and through the use of terminology.

Increasingly, it seems that people in Hargeisa make use of medical staff and equipment when undergoing the procedure and the practice is increasingly framed within a biomedical discourse. This of course creates ambiguities in relation to eradication of the phenomenon as a sole focus on health complications may lead to abandonment, while at the same time it can legitimise certain practices. Consequently, there is a move towards approaching FGC as a social issue with potential medical implications, rather than simply as a medical issue.

By approaching FGC as a social issue one can see that eradication and abandonment can be based both on initiatives designed to eradicate the practice and more informally on social interactions between, for example, family and friends. It was also seen that social change is enabling traditional decision-makers to be challenged. This was particularly apparent in changing gender roles and in the role between older and younger generations. Furthermore, religious ideas and institutions play a crucial role in FGC. Whether religion will remain a barrier or a facilitator to eradication is something that is being vigorously negotiated.

The use of terminology was also seen as an important element in comprehending current FGC practices. Although pharaonic circumcision is looked upon negatively as a harmful and traditional practice and sunna circumcision is looked upon as a more modern and milder practice, a lack of definitional clarity means that actual practices remain uncertain. What does appear certain is that changing terminology offers the opportunity for social change. Therefore how sunna comes to be defined can become a crucial battle ground in the drive to change practices of FGC.

Organisations adopting an all-or-nothing approach to eradication therefore risk losing valuable opportunities to play a role in redefining how FGC is practiced.

FGC and FGC eradication is far from a biomedical story of vaginas only. It may be argued that it is not even about vaginas, but rather about cultural and social processes that act out in a diversity of ways. This thesis sees FGC eradication as one of the many small pieces that constitute a complex puzzle of 'development'. It does not aim to provide a solution to issues of FGC, it is rather envisioned that the data gained may be used as a tool to reconsider current action to fight FGC. This study provides one understanding of FGC which can contribute in framing future FGC-discourse.

Previously a common assumption of the world, in anthropology, is that it is bounded by homogenous cultures and nation-states. Increasingly culture is viewed as not static where



individuals within it owns agency (Smart, 1982; Talle, 2010). Social change thus happens, but in complex ways. What is clear when it comes to eradicating FGC is that the future is uncertain and that reality conceptions are part of a larger socially constructed world. The reality conceptions explored in this study are viewed, at least at a meta-level, as a constantly evolving conversation that provides a useful lens through which to examine FGC. It is obvious that understandings of what FGC constitutes are complex, contradictory and far from clear-cut. Nonetheless, through constant negotiation of 'reality' different paths emerge, and eradication of FGC may somehow appear along what can seem like a messy path.



## Reference list

- Abby, A., & Mahamoud, D. (2005). Internally displaced minorities in Somalia and Somaliland. Retrieved from <http://www.mbali.info/doc345.htm>
- Abu-Lughod, L. (1991). Writing against culture. In R. Fox (Ed.), *Recapturing anthropology* (pp. 137-162). Santa Fe: School of American Research Press.
- Abu-Sahlieh, S. A. A. (1999). Muslims' genitalia in the hands of the clergy: Religious arguments about male and female circumcision. In G. C. Denniston, F. M. Hodges & M. F. Milos (Eds.), *Male and female circumcision: Medical, legal and ethical considerations in pediatric practice* (pp. 131-172). New York: Plenum Publishers.
- Afrol. (2011). FGM map. Retrieved from [http://www.afrol.com/html/Categories/Women/FGM/fgm\\_map.htm](http://www.afrol.com/html/Categories/Women/FGM/fgm_map.htm)
- Akou, H. M. (2011). *The politics of dress in Somali culture*. Bloomington: Indiana University Press.
- Alice, L. (2003). Power, Experience, and Process in Feminist Research. In C. a. T. Davidson, Martin (Ed.), *Social science research in New Zealand: Many paths to understanding* (2nd ed., pp. 62-69). Rosedale: Pearson Education New Zealand.
- Anderson, B. (1983). *Imagined communities: Reflections on the origin and spread of nationalism*. London: Verso Editions.
- Ansorge, R. (2011). *Evaluation report: Female genital mutilation/cutting programme 2009-2014*. Somaliland: Somali Red Crescent Society Somaliland.
- Baruud, M. (2008). *Somaliland female genital mutilation abandonment survey: Assessment study*. Hargeisa, Somaliland: The Nafis network.
- Bisset, K., Galloway, E., Parker, L., & Vogel, B. (2010). Conflict Map Somalia. Retrieved from [http://www.st-andrews.ac.uk/intrel/media/100727\\_Somalia%20map\\_%20final%20final%20version.pdf](http://www.st-andrews.ac.uk/intrel/media/100727_Somalia%20map_%20final%20final%20version.pdf)
- Black, M. (2010). Eradication of Female Genital Mutilation in Somalia. Somalia: UNICEF.
- Boddy, J. (2008). Clash of selves: Gender, personhood, and human rights discourse in colonial Sudan. *Finnish Journal of Ethnicity and Migration*, 3(2), 4-13.
- Bodley, J. H. (2005). Understanding culture. In J. H. Bodley (Ed.), *Cultural anthropology: Tribes, states and the global system* (pp. 2-30). Boston: McGraw Hill Education.
- Bradbury, M. (2008). *Becoming Somaliland*. Bloomington: Indiana University Press.
- Bryman, A. (2004). *Social Research Methods* Oxford: Oxford University Press.
- Burrell, G. (1988). Modernism, Post Modernism and Organizational Analysis 2: The Contribution of Michel Foucault. *Organisation Studies*, 9(2), 221-235.
- Candlelight. (2008). Candlelight safe motherhood programs that implemented from: 2000-2008 in Somali land regions. Hargeisa, Somaliland: Candlelight for Health Education and Environment.
- Chacko, E. (2004). Bridging feminist theory and research methodology. *Journal of Family Issues*, 25, 963-977.
- Clarence-Smith, W. G. (2008). Islam and female genital cutting in Southeast Asia: The weight of the past. *Finnish Journal of Ethnicity and Migration*, 3(2), 14-22.
- Collier, R. (2011). Ugly, messy and nasty debate surrounds circumcision. *Canadian Medical Association, Early release, subject to revision*, 1-3.
- Crotty, M. (2009). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications London.
- Danaher, G., Schirato, T., & Webb, J. (2000). *Understanding Foucault*. Sydney: Allen & Unwin.
- Davidson, C., & Tolich, M. (2003). *Social science research in New Zealand: Many paths to understanding* (2nd ed.). Rosedale: Pearson Education New Zealand.
- Dawson, A. (2009). Positionality and role-identity in a new religious context: Participant observation at Ceu do Mapia. *Religion*, 10, 1-9.
- Diop, M., & Ba, F. (2004). Female genital mutilation/cutting in Somalia. Kenya: United Nations Population Fund and World Bank.

- Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. New South Wales: Allen and Unwin.
- Fangen, K. (2004). *Deltagende observasjon*. Bergen: Fagbokforlaget.
- Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings 1972-1977*. Brighton: Harvester Press.
- Gardner, H. (1973). Levi-Strauss. In H. Gardner (Ed.), *Quest for the human mind: Piaget, Levi-Strauss and the structuralist movement* (pp. 111-162). Chicago: University of Chicago Press.
- Gele, A. A., Kumar, B., Hjelde, K. H., & Sundby, J. (2012). Attitudes toward female circumcision among Somali immigrants in Oslo: A qualitative study. *International Journal of Women's Health*, 4, 7-17.
- Gottfried, H. (1996). *Feminism and Social Change*. Chicago: University of Illinois Press.
- Gove, J., & Watt, S. (2000). Identity and gender. In K. Woodward (Ed.), *Questioning identity: Gender, class, nation* (pp. 44-77). Milton Keynes: Open University Press.
- Gulaid, U. J. (2008). The challenge of female genital mutilation in Somaliland: Ongoing research and policy discussions. *Finnish Journal of Ethnicity and Migration*, 3(2), 90-91.
- Hajer, M. (1993). Discourse coalitions and the institutionalisation of practice: The case of acid rain in Great Britain. In F. Fischer & J. Forester (Eds.), *The argumentative turn in policy analysis and planning* (pp. 43-76). Durham: Duke University Press.
- Helander, B. (1990). Getting the most out of it: Nomadic health care seeking and the state in southern Somalia. *Nomadic People*, 25(27), 122-132.
- Hellevik, O. (2007). I hvilket omfang blir jenter med somaliske foreldre bosatt i Norge omskåret? En vurdering av hva som kan ligge bak to meget ulike situasjonsbeskrivelser. Retrieved from <http://www.nrk.no/nyheter/norge/1.4176867>
- Hosken, F. P. (1976). Genital mutilation of women in Africa. *Munger Africana Library Notes*, 36, 3-21.
- IDMC. (2010). Somalia: Displacement and worsening humanitarian situation as a result of ongoing violence and conflict. Retrieved from <http://www.internal-displacement.org/8025708F004CE90B/%28httpCountries%29/02EE5A59E76049F5802570A7004B80AB?OpenDocument>
- Ingstad, B. (2007). *Medisinsk antropologi: En innføring*. Bergen: Fagbokforlaget.
- Ismail, E. A. (2009). *Female genital mutilation survey in Somaliland*. Hargeisa: The Edna Adan Maternity and Teaching Hospital.
- Johansen, E. B., Bathija, H., & Khanna, J. (2008). Work of the World Health Organisation on female genital mutilation: Ongoing research and policy discussion. *Finnish Journal of Ethnicity and Migration*, 3(2), 83-89.
- Johnsdotter, S. (2008). Popular notions of FGC in Sweden: The case of Ali Elmi. *Finnish Journal of Ethnicity and Migration*, 3(2), 74-82.
- Johnsdotter, S. (2012). Projected cultural histories of the cutting of female genitalia: A poor reflection as in a mirror. *History and Anthropology*, 23(1), 91-114.
- Kunnskapssenteret. (2009). Effectiveness of interventions designed to reduce the prevalence of female genital mutilation/cutting: Systematic review *Report 25*. Oslo, Norway: Kunnskapssenteret.
- Lewis. (2002). *A Modern History of the Somali Nation and State in the Horn of Africa* (4th ed.). Oxford: Longman Group United Kingdom.
- Lewis, H. (1995). Between irua and 'female genital mutilation': Feminist human rights discourse and the cultural divide. *Harvard Human Rights Journal*, 1, 1-55.
- Linard, C., Alegana, V. A., Abdisalan, M. N., Snow, R. W., & Tatem, A. J. (2010). A high resolution spatial population database of Somalia for disease risk mapping. *International Journal of Health Geographics*, 9(45), 1-13.
- Mazzilli, C., & Davis, A. (2009). Health care seeking behaviour in Somalia: A literature review. Somalia: UNICEF.

- Merli, C. (2008). Sunat for girls in southern Thailand: Its relation to traditional midwifery, male circumcision and other obstetrical practices. *Finnish Journal of Ethnicity and Migration*, 3(2), 32-41.
- Merquior, J. G. (1985). *Foucault*. Berkely: University of California Press.
- MICS. (2006). Somalia: Multiple indicator cluster survey. Geneva: UNICEF.
- Ministry of Family Affairs and Social Development. (2008). *Second draft national gender policy framework 2008-2011: Submitted to the council of ministers government of the Republic of Somaliland*. Hargeisa, Somaliland.
- Ministry of Labour and Social Affairs. (2011). *National Plan against FGM in Somaliland*. Hargeisa, Somaliland.
- Morris, R. (1996). The culture of female circumcision. *Advances in Nursing Science*, 9(2), 43-53.
- Musse, F. (2011). *Coordination and Collaboration: FGM consultation work-shop*. Hargeisa: The Pentecostal Foreign Mission of Norway Aid.
- Nafis. (2006). NAFIS-stop FGC. Hargeisa, Somaliland: Nafis.
- Obermeyer, C. M. (1999). Female genital surgeries: The Known, the Unknown, and the Unknowable. *Medical Anthropology Quarterly*, 13(1), 79-106.
- Ortner, S. B. (1995). Resistance and the problem of ethnographic refusal. *Comparative Studies in Society and History*, 37(1), 173-193.
- Peet, R. (2005). *Theories of Development*. New York: The Guilford Press.
- Petchesky, R. P. (2008). Conflict and Crisis Settings: Promoting Sexual and Reproductive Rights. *Reproductive Health Matters*, 16(31), 4-9.
- Pickett, B. L. (1996). Foucault and the politics of resistance. *Polity*, 28(4), 445-466.
- Pieterse, J. N. (1998). My paradigm or yours? Alternative development, post-development, reflexive development. *Development and Change*, 29, 343-373.
- Putrani, B. D. (2008). To islamise, becoming a real woman or commercialised practices? Questioning female genital cutting in Indonesia. *Finnish Journal of Ethnicity and Migration*, 3(2), 23-31.
- Rafti, P. (1979). The Hosken Report: Genital/sexual mutilation of females by Fran P. Hosken. *Medical Anthropology Newsletter*, 11, 19-20.
- Ramazanoglu, C., & Holland, J. (2003). *Feminist Methodology: Challenges and Choices*. London: Sage Publications Ltd.
- Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: Are there special issues for health services research. *Family Practice*, 19, 135-139.
- Rist, G. (1997). *The history of development: From Western origins to global faith*. London: Zed Books Ltd.
- Rosalind, E., & Moncrieffe, J. (2006). The power of labelling in development practice. *IDS Policy Briefing*, 28.
- Rothe, J. P. (1993). *Qualitative Research: A Practical Guide*. Toronto: RCI/PDE Publications.
- Saul, J. (2004). Globalisation, imperialism, development: False binaries and radical resolutions. *Socialist Register*, 40, 220-245.
- Saussy, H., & Kidder, T. (2010). *Partner to the Poor: A Paul Farmer Reader*. London: University of California Press.
- Smart, B. (1982). Foucault, Sociology and the Problem of Human Agency. *Theory and Society*, 11(2), 121-141.
- Smith, M. W. (1995). Ethics in focus groups: A few concerns. *Qualitative Health Research*, 5, 478-486.
- Sorbye, I., & Leigh, B. (2009). Reproductive health national strategy and action plan 2010-2015: Somalia. Somalia: WHO.
- Spencer, J. (2008). A nationalism without politics? The illiberal consequences of liberal institutions in Sri Lanka. *Third World Quarterly*, 29(3), 611-629.
- Talle, A. (2008). Precarious identities: Somali women in exile. *Finnish Journal of Ethnicity and Migration*, 3(2), 64-73.

- Talle, A. (2010). *Kulturens makt: Kvinnelig omskjæring som tradisjon og tabu*. Kristiansand: Høyskoleforlaget AS.
- Tiilikainen, M., & Johansson, J. (2008). Introduction. *Finnish journal of ethnicity and migration*, 3(2), 2-3.
- Totsan. (2011). My daughter dry your tears. Retrieved from <http://vimeo.com/32516740>
- Toubia, N. (1988). Women and health in Sudan. In N. Toubia (Ed.), *Women of the Arab World: The Coming Challenge* (pp. 98–109). London: Zed Books.
- Toubia, N. (1994). Female circumcision as a public health issue. *The New England Journal of Medicine*, 331(11), 712-716.
- Toubia, N., & Sharief, E. H. (2003). Female genital mutilation: Have we made progress? *International Journal of Gynecology and Obstetric*, 82(3), 251-261.
- UNFPA. (2007). Somali men and women united against female genital mutilation: Somali experts round table Hargeisa and Garowe. Hargeisa, Somaliland.
- UNHCR. (2011). UNHCR country profile: Somalia. Retrieved from <http://www.unhcr.org/pages/49e483ad6.html>
- UNICEF. (2011). *Conceptual framework for child protection system in Somaliland*. Paper presented at the Mapping child protection systems in Somaliland: Validation workshop, Hargeisa, Somaliland.
- Wade, L. (2011). Learning from "female genital mutilation": Lessons from 30 years of academic discourse. *Ethnicities*, 12(1), 26-49.
- WHO. (1997). Female Genital Mutilation: A joint WHO/UNICEF/UNFPA statement. Geneva: World Health Organisation.
- WHO. (2000). A systematic review of the health complications of female genital mutilation including sequelae at birth. Geneva: World Health Organisation.
- WHO. (2003). Female genital mutilation: A teacher's guide. Geneva: WHO.
- WHO. (2007). Male circumcision: An intervention for HIV prevention in the WHO African region. Geneva: WHO.
- WHO. (2008). World health assembly 61: Resolutions and decisions. *Eighth plenary meeting*. Retrieved from [http://www.who.int/reproductivehealth/topics/fgm/fgm\\_resolution\\_61.16.pdf](http://www.who.int/reproductivehealth/topics/fgm/fgm_resolution_61.16.pdf)
- WHO. (2011a). Maternal mortality indicators. Retrieved from <http://apps.who.int/ghodata/?vid=240>
- WHO. (2011b). An update on WHO's work on female genital mutilation (FGM): Progress report. Geneva: World Health Organisation.
- WHO. (2012). Maternal mortality ratio (per 100 000 live births). Retrieved from <http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html>
- Wisdom, T. (2012). Questioning circumcisionism: Feminism, gender equity, and human rights. *Righting Wrongs*, 2(1).

## Appendix 1: Interview guide for initial interviews

**Aim of interview:** Overview over who is doing what and reproductive health and IDPs

### Introduction:

1. Me: My background and staying in Somaliland from September to December to collect data. The research: Reproductive health and internally displaced people (IDPs) in Somaliland. This is first stage of the research project and the aim is to get an overview and to identify a research question. Second stage is to narrow the research topic down and collect data based on the identified research question. I will ask you questions about what your organisation does and your opinions about the work of your organisation and reproductive health care delivery in general in Somaliland.
2. You are part of my data collection and I might use narratives and quotes in my final publications which will be a thesis and maybe an academic journal. Your participation is confidential, so neither you nor the name of your agency will be identified in any way. But I would like to record it so I have as accurate information as possible. Is this ok with you? If not, we can take notes instead.

### Themes to cover:

- Local definitions and understandings of reproductive health and related needs
- Reproductive health services available for IDPs
- Experiences with use of reproductive health services by IDPs
- Availability, affordability and accessibility of reproductive health services
- Barriers to reproductive health services
- Facilitators of reproductive health services
- Research needed

### Example of specific questions:

- Can you first tell me a little about what your organisation does?
- Can you tell me about the reproductive health services are available in Hargeisa?
  - What problems are associated with reproductive health in Somaliland?
  - What organisations work with reproductive health?
- What do you think is working well with reproductive health?
- What improvements could be made in the provision of reproductive health?
- How do you define reproductive health?
- Do you know what reproductive health services are available to IDPs?
  - Who works on reproductive health for IDPs in Hargeisa?
  - How do you define IDP? (Refugee?)
  - (What do you think is working well with reproductive health and IDP?
  - What improvements could be made in the provision of reproductive health?)
- Are there any coordination mechanisms for health/ reproductive health?
  - For IDPs?
- Main challenges to providing the reproductive health services for IDPs?
- What are the main barriers to access reproductive health, you think?
  - For IDPs?
- What research is needed on reproductive health care in Somaliland?
- Contact details

### After the formal interview is over, and the tape recorder switched off:

- Give 'information sheet for research participants' and point out the contact details
- Ask if there are any questions about the research or their participation in the research

## Appendix 2: Interview guide for organisations working on FGM/C

**Aim of interview:** Overview over who is doing what on FGM/C-work. Opinions of FGM/C and eradication approaches

### Introduction:

1. Me: My background and staying in Somaliland from September to December to collect data. The research: Perceptions of FGM/C and eradication in Somaliland. I will ask you questions about what your organisation does and your opinions about the work of your organisation and FGM/C in general in Somaliland.
2. You are part of my data collection and I might use narratives and quotes in my final publications which will be part of a thesis and an academic journal. Your participation is confidential, so neither you nor the name of your organisation will be identified in any way. But I would like to record it so I have as accurate information as possible. Is this ok with you? If not, we can take notes instead.
3. Do you want to participate?

### Themes to cover:

- FGM/C-work
- FGM/C- practices
- Medical complications associated with circumcision
- Challenges and facilitators of eradication

### Examples of specific questions:

1. Can you tell me what work your organisation does?
2. What work do you do on FGM/C?
  - a. When did it start?
  - b. Where do you get your funds from?
  - c. Who do you partner with?
  - d. What improvements have you seen?
  - e. What challenges are still to be met?
3. Who else works on FGM/C in Somaliland?
4. What types of FGM is present in Somaliland based on your experience?
  - a. Do you see the sunna or the pharaonic type the most?
  - b. What are the health problems that you see that is related to sunna type?
    - i. What is so bad about sunna?
  - c. What are the health problems that you see that is related to the pharaonic type?
5. Should eradication of FGM/C be a priority for the health needs of the women in Somaliland? Why/why not?
  - a. What needs to be done to eradicate FGM?
    - i. Do you think it is possible?
6. How do you think FGM/C is understood in Somali culture?
  - a. Why is FGM/C still so prevalent? Why do people circumcise nowadays?
  - b. Do you think the people see FGM/C as a health problem? How?
    - i. Do you think people believe that the complications they experience is related to FGM/C?
7. Do you know someone who does not circumcise their daughter?
  - a. What are their reasons?
  - b. What challenges do they meet?
8. Do you have any documents/reports I could have a look at?

### After the formal interview is over, and the tape recorder switched off:

- Give 'information sheet for research participants' and point out the contact details
- Ask if there are any questions to me, about the research or their participation in the research



## Appendix 3: Interview guide for interviews with ‘lay’ people

### Perceptions of female genital circumcision in Hargeisa

#### Interview guide

##### Introduction/Before the interview starts:

- My name is [NAME], and I am a research assistant and interpreter of this project.
- Ingvild is a master student in international community health at the University of Oslo, and this research project is part of her master degree.
- She is in Hargeisa from September-December to collect data
- The overall aim of this research project is to get an understanding of the perceptions of circumcision and campaigns to eradicate it in Somaliland
- Neither I nor Ingvild make any judgements on your opinions
- The researcher will benefit from your personal opinions on female circumcision
- Ingvild will listen to the interview and I will shortly translate to her throughout the interview, she might have additional questions that she will ask.
- You are part of Ingvild's data collection and she might use narratives and quotes in her final publications which will be a master thesis and maybe an academic journal.
- Your participation in the research is confidential, your name will never be written down and the researcher will secure your anonymity.
  - If you are willing for the researcher to record your age she will
- Your participation is voluntarily and you can withdraw you participation now, during the interview or any time before the write-up of the final report begins in January 2012
- If you do not want to answer some of the questions you are free to refuse answering them.
- We expect the interview to last between 1-2 hours. Is that ok with you?
- Are you willing to participate in this research?
- Is it ok if I record the interview? I do this to better remember what we talk about.
  - I will delete the recording on completion of the project in June 2012

##### Themes that will be covered are:

- Medical complications associated with circumcision
- Experiences of circumcision, not personal
- Training gained related to circumcision
- Views on eradication of circumcision
- Views on beliefs associated with circumcision
- If appropriate: Views on your role as a health professional in relation to your personal opinions on the topic

**Do you want to start the interview? Remember that you can stop the interview at anytime or chose not to answer the questions. (Turn the tape recorder on if ok.)**

##### Examples of specific questions:

1. What is your profession/What do you do in your job?
2. What are your thoughts on FGM?
3. Can you tell me about some of the main problems women experience in regards to their health in Hargeisa region?
4. Can you tell me about your work experiences with FGM/C and women's health in Somaliland?
  - a. What type of circumcision do you see the most?
  - b. How do you think FGC is related to women's health?
5. Is FGM/C a topic at your workplace?
  - a. What training have you gained about the topic?
6. Why do people circumcise?
7. Are there any initiatives taken to eradicate FGM/C in Hargeisa?
  - a. If yes:
    - i. What are they?

- ii. How do they influence Somali culture?
    - iii. Do you think they work well? Why/Why not?
  - b. If no:
    - i. Why do you think there are none?
    - ii. Do you think an FGM/C eradication campaign would work? Why/why not?
    - iii. How would eradication of FGM/C influence Somali culture?
- 8. What do you think if the government banned FGM?
- 9. Do you know someone that does circumcise their daughters?
  - a. Why do they do it?
  - b. What type of circumcision do they do?
    - i. Why?
  - c. Do you think they would stop doing it if it was acceptable by society? Why/why not?
- 10. Who do you think would not circumcise their daughters? Do you know anyone?
  - i. What would their reasons be?
- 11. If you had a daughter who would be at the age of circumcision, would you want to circumcise her?
  - a. Why/why not?
  - b. What type of circumcision would you do? Why?
  - c. What would the challenges be for you if you did not circumcise her?
  - d. What would the challenges be for your daughter if you did no circumcise her?
- 12. Does Ingvid have any more questions?
- 13. Is there anything else you would like to add?

**After the formal interview is over, and the tape recorder switched off:**

- 1. Is it ok if I refer to your age in my final written report? If yes, what is it?
- 2. Do you have any questions to the researcher?
- 3. Do you know anyone else who might be interested in participating in this research?
- 4. (Give the information sheet to the research participant)

## Appendix 4: Ethical approvals and statement of confidentiality made by research assistant



UNIVERSITETET I OSLO  
DET MEDISINSKE FAKULTET

KOPI

Mette Sagbakken  
International Community Health  
University of Oslo  
P.Box 1130 Blindern  
N-0318 Oslo

Regional Committee for Medical Research  
South-East Norway, Section C  
P.B 1130 Blindern  
NO-0318 Oslo

Phone: +47 22 84 55 21

Date: 22.06.2011  
Your ref.: 2011/955  
Our ref.: IRB 0000 1870

E-mail: [post@helseforskning.etikkom.no](mailto:post@helseforskning.etikkom.no)  
Homepage: <http://helseforskning.etikkom.no>

### To whom it may concern

With regards to the study *The use and needs of reproductive health care services amongst internally displaced persons in Somalia*.

We hereby confirm that the Regional Committee for Medical and Health Research Ethics, section South-East C, Norway has received the project *The use and needs of reproductive health care services amongst internally displaced persons in Somalia* for review. The project was discussed on the 4<sup>th</sup> of May 2011.

The ethics committee system consists of seven independent regional committees, with authority to either approve or disapprove medical research studies conducted within Norway, or by Norwegian institutions, in accordance with ACT 2008-06-20 no. 44: Act on medical and health research (the Health Research Act).

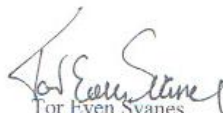
The abovementioned study is exempt from review in Norway, as its principal aim is to further knowledge regarding the organization of healthcare in Somalia, not to specifically study health and disease as such, cf. § 4.

Please do not hesitate to contact the Regional Committee for Medical and Health Research Ethics, section South-East C (REK Sør-Øst C) if further information is required.

Yours sincerely,

Arvid Heiberg MD, PhD (sign.)  
Professor of Medicine,  
University of Oslo

Chair, Regional Committee  
for Medical and Health Research Ethics,  
section South-East C

  
Tor Even Svanes  
Senior Advisor

Regional Committee for  
Medical and Health  
Research Ethics, section  
South-East C

Copy: Ingvild Bergom Lunde, Veslekroken 1, 0379 Oslo



Harald Hårfagres gate 29  
N-5007 Bergen  
Norway  
Tel: +47-55 58 21 17  
Fax: +47-55 58 96 50  
nsd@nsd.uib.no  
www.nsd.uib.no  
Org.nr. 985 321 884

Ingvil Sørbye  
Avdeling for samfunnsmedisin  
Institutt for helse og samfunn  
Universitetet i Oslo  
Postboks 1130 Blindern  
0318 OSLO

Vår dato: 06.07.2011

Vår ref: 27345 / 3 / LMR

Deres dato:

Deres ref:

#### TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 05.06.2011. Meldingen gjelder prosjektet:

27345	<i>Reproduktive helsetjenester for internt fordrevne personer i Somaliland</i>
Behandlingsansvarlig	<i>Universitetet i Oslo, ved institusjonens øverste leder</i>
Daglig ansvarlig	<i>Ingvil Sørbye</i>
Student	<i>Ingvild Bergom Lunde</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, [http://www.nsd.uib.no/personvern/forsk\\_stud/skjema.html](http://www.nsd.uib.no/personvern/forsk_stud/skjema.html). Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 01.07.2012, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen  
  
Vigdis Namtvedt Kvalheim

Linn-Merethe Rød

Kontaktperson: Linn-Merethe Rød tlf: 55 58 89 11

Vedlegg: Prosjektvurdering

Kopi: Ingvild Bergom Lunde, Veslekroken 1, 0379 OSLO

Avdelingskontorer / District Offices:

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. [nsd@uio.no](mailto:nsd@uio.no)  
TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. [kym.svanval@svt.ntnu.no](mailto:kym.svanval@svt.ntnu.no)  
TROMSØ: NSD, HSL, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. [marlin-ame.andersen@uit.no](mailto:marlin-ame.andersen@uit.no)

From: **Linn-Merethe Rød** (linn.rod@nsd.uib.no)

Sent: Monday, November 28, 2011 11:04:30 AM

To: ingvildlude@windowslive.com

Cc: ingvil.sorbye@medisin.uio.no

Viser til innsendt endringsmelding for prosjektet 27345 "Perceptions of female genital circumcision as a health problem in Somaliland".

Personvernombudet har registrert at formålet med prosjektet er endret til å se på hvordan tiltak for å utrydde omskjæring fungerer i Somaliland. Utvalget består nå av helsepersonell og nøkkelpersoner med perspektiver/synspunkter vedrørende omskjæring. Tittel for prosjektet er endret til "Perceptions of female genital circumcision as a health problem in Somaliland".

Videre har vi registrert at det ikke innhentes sensitive opplysninger om helse eller seksuelle forhold. Sensitive opplysninger om religiøse/politiske synspunkter vil fremdeles bli behandlet.

Ta gjerne kontakt dersom noe er uklart.

--

Vennlig hilsen

Linn-Merethe Rød

Seniorrådgiver

Norsk samfunnsvitenskapelig datatjeneste AS

Personvernombud for forskning

Harald Hårfagres gate 29, 5007 BERGEN

Tlf. direkte: (+47) 55 58 89 11

Tlf. sentral: (+47) 55 58 21 17

Faks: (+47) 55 58 96 50

E-post: [Linn.Rod@nsd.uib.no](mailto:Linn.Rod@nsd.uib.no)

[www.nsd.uib.no/personvern](http://www.nsd.uib.no/personvern)



# University of Hargeisa

## Faculty of Medicine

Tel: +002522525772 (Tales), +002522825499 (Salt), +002522188510 (Stc).

Email Address: [medicine@hargeisauniversity.com](mailto:medicine@hargeisauniversity.com)

Site: [www.hargeisauniversity.com](http://www.hargeisauniversity.com)

Ref. 27/10/2011

27/10/2011

**TO:** Director General, Ministry of Health

**Cc:** President of Hargeisa University

**Cc:** Ingrid lunde

**Sir,**

I have the pleasure to forward the beginning of research to be done by Ingrid lunde on perception of Female Genital Cutting as a Health problems in Somaliland the researched in from Oslo University which is a partner of Hargeisa University I would appreciate much of I could approve or permit the researchers to conduct this work.

Thank you,

  
Dr, Derie Ismail Ereg

Dean Faculty of Medicine



**DECLARATION OF CONFIDENTIALITY AND ANONYMITY OF RESEARCH PARTICIPANTS**

Title of project: Perceptions of female genital circumcision as a health problem in Hargeisa

Please circle your answer:

I have been given and have understood an explanation of this research project and its ethical challenges. And I have had an opportunity to ask questions and to have them answered to my satisfaction.	<input checked="" type="radio"/> YES <input type="radio"/> NO
I understand that I can never identify the research participants and their opinions shared.	<input checked="" type="radio"/> YES <input type="radio"/> NO
I understand that if I know any of the research participants I will have to inform the researcher, Ingvild Lunde, immediately.	<input checked="" type="radio"/> YES <input type="radio"/> NO
I understand that the personal data provided to me will remain confidential and will not be used for any other purpose than assisting in the research project.	<input checked="" type="radio"/> YES <input type="radio"/> NO

Name in print:

Zuhur Mohamed Abdi

Signed:



Place /Date:

refufo



## Appendix 5: Information sheet for research participants

### Research project: Perceptions of female genital circumcision in Somaliland

#### *Information sheet for research participants*

The aim of this research project is to gain an understanding of how female genital circumcision is perceived in Somaliland. My name is Ingvild Lunde, and I am a student at the University of Oslo and undertaking this research project as a part of a master degree in International Community Health. The research will be based primarily on documents from international agreements, policy documents, conference papers and previous academic research as well as personal accounts from persons working and not working directly on FGC related issues. The data collection is conducted between September-December 2011. The aim is to finish the final report in the form of a master thesis in June 2012. The findings may also be published as short reports in academic journals. It is envisaged that this research will be useful for planning FGM/C interventions in Somaliland.

Participation is voluntary and interviewees can choose to withdraw their information at any stage *before* the writing up of the final report begins (January 2011). All the information I and/or the research assistant receive will be treated with strict confidentiality and neither your name nor workplace will be connected to any of the information used in the final report. Any voice recordings and personal data will be deleted upon completion of the project.

The project is approved by the Data Protection Official for Research, Norwegian Social Science Data Services in Norway. I have received a scholarship from the project LEVE (Livelihoods in Developing Countries). LEVE is an interfaculty programme that belongs to the Centre for Development and the Environment (SUM) housed at the University of Oslo.

If you have any questions or would like to receive further information about the project and your participation in it, my contact details are:

Email: [i.b.lunde@studmed.uio.no](mailto:i.b.lunde@studmed.uio.no)

Phone: Somaliland: 4767497 (telesom) / Norway: +47 48150763

You can also contact my research assistant, Zuhuur:

Phone: 4121623

You can also contact my supervisor, associate professor Mette Sagbakken, at [mette.sagbakken@medisin.uio.no](mailto:mette.sagbakken@medisin.uio.no)



